

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 07/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

R0000	<p>This visit was for the Investigation of Complaint IN00108885.</p> <p>Complaint IN00108885-Substantiated. State residential deficiencies related to the allegation are cited at R0052.</p> <p>Survey date: July 3, 2012</p> <p>Facility number: 010890 Provider number: 010890 AIM number: N/A</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: Residential: 103 Total: 103</p> <p>Census payor type: Other: 103 Total: 103</p> <p>Sample: 7</p> <p>This state residential finding was cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 9, 2012 by Bev Faulkner, RN</p>	R0000	<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>	
-------	--	-------	---	--

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.

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 07/03/2012	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R0052	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on observation, record review, and interview, the facility failed to protect a resident from possible abuse related to not addressing reported staff concerns of inappropriate physical contact between a resident and a visitor. (Resident #B)</p> <p>Findings include:</p> <p>On 7/3/12 at 9:45 a.m., Resident #B was observed sitting in a chair next to a table in her room. CNA's #1 and #2 assisted the resident to a standing position and then the resident ambulated to the bathroom with assistance and cueing from the CNA's.</p> <p>The clinical record for Resident #B was reviewed on 7/3/11 at 10:00 a.m. The resident was admitted to the facility on 9/14/2010. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety disorder, carotid stenosis, seizures, cerebral vascular accident (stroke), and macular</p>	R0052	<p>Corrective action accomplished for those residents found to have been affected by this deficient practice: An Unusual Occurrence Report / Reasonable Suspicion of a Crime against a Resident Report was sent to the ISDH on July 3, 2012 regarding the suspected inappropriate sexual behavior between Resident #B and her nephew. The five-day follow up was completed with the investigation being on-going. Brentwood is working with Adult Protective Services and local Police Department detective. Please note that the July 3rd date is not the completion date for the POC. Its the date we submitted an Unusual Occurrence Report. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Review of 24 hour sheets for the past month along with employee interviews indicate that no other residents have been found to be affected. An Unusual</p>	07/19/2012			

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 07/03/2012	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>degeneration.</p> <p>Review of the 6/6/12 bi-annual assessment indicated the resident had periods of confusion, was forgetful, and was understood sometimes. The assessment also indicated the resident required cueing for mobility and needed reminders and cueing at meal times. The 6/8/12 Individualized Service Plan indicated the resident had periods of confusion and forgetfulness and needed reminders to find areas in the facility. The Service plan also indicated the resident required assistance from one person with showering and bathing and occasionally resisted care.</p> <p>Review of the Service Notes from 2/2012 thru 7/2/2012 indicated there was no documentation of the any inappropriate interactions between the resident and any visitors.</p> <p>When interviewed on 7/3/12 at 11:00 a.m., CNA#1 indicated a male relative often visits the resident. The CNA indicated she had observed the visitor laying in bed behind the resident with his arms around her and holding her. The CNA indicated other staff members told her the visitor gives the resident showers and changes her. The CNA also indicated she last saw the visitor in a month or so</p>		<p>Occurrence/Reasonable Suspicion of a Crime Report will be completed in the event the on-going investigation identifies a resident that has been affected.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice doesn't recur: Employees have been re-in-serviced on the Abuse Policy and Mandatory Reporting. This will include the Complaint Log. Executive Director will re-in-service Employees on the Ethics First Policy on July 18, 2012. This Policy allows employees to anonymously voice issues/concerns directly to the Corporate Office. Resident Care Coordinator will re-in-service Nursing Employees on documentation July 18,2012, with emphasis on the 24 hour Report. Executive Director will present Resident Rights at the July 16, 2012 Resident Council meeting. Executive Director will review Complaint Policy during this July 16, 2012 meeting. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Resident Care Coordinator /Designee will review the 24 Hour report no less the 5 times per week to identify incidents or issues that require additional follow up that may include the Reporting an Unusual</p>				

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 07/03/2012	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>ago and she had reported it the nurse.</p> <p>When interviewed on 7/3/12 at 11:00 a.m., along with CNA#1, CNA#2 indicated when the male visitor goes in the room he wants to be left alone and does not want staff in there. CNA #2 indicated staff from another shift told her that the visitor was recently seen in the bed with the resident.</p> <p>When interviewed on 7/3/12 at 11:15 a.m., LPN #1 indicated she started working at the facility at the end of February 2012. The LPN indicated when she first started working it was reported to her to "keep an eye" on him (a male visitor for Resident #B) as he has been inappropriate and had been in bed with the resident. LPN#1 also indicated when she first started the CNA's told her it usually occurred on the second shift and the CNA's had said it didn't look right to them. The LPN indicated she had not observed this herself and assumed the Administration knew about it. The LPN indicated she worked days now but had picked up a few evening shifts when she first started working at the facility.</p> <p>When interviewed on 7/3/12 at 12:05 p.m., via telephone the Resident Care Coordinator indicated she had started working at this facility around the end of</p>		<p>Occurrence. The Resident care Coordinator and Executive Director will continue to conduct "Resident Rounds" no less then 3 times weekly to allow residents face to face opportunity to voice concerns. Executive Director to review Complaint Log weekly to ensure Resident Grievances are addressed timely. Date of Completion: In-services to be completed by July 18, ,2012. Other areas will be on-going.</p>				

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 07/03/2012	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>October 2011 or first of November 2011. She indicated the Executive Director at that time gave her a synopsis of the residents and told her about an event involving a CNA finding Resident #B and a male visitor in bed. She indicated this Executive Director left the facility around January 2012. The Resident Care Coordinator indicated approximately last week staff reported Resident #B was more agitated on the evening shift after a male visitor that was with her left. She indicated prior to last week no incidents involving the resident's visitor had been reported to her. She indicated she had never witnessed any inappropriate activity with the visitor and resident.</p> <p>When interviewed on 7/3/12 at 11:30 a.m., the Executive Director indicated he had just spoken with the above two CNA's and they provided him with statement regarding possible inappropriate behavior between Resident #B and her visitor. The Executive Director indicated based on the statements he had just received he was initiating a complete investigation. The Executive Director indicated he began working at the facility a few weeks ago and had no knowledge of the occurrences.</p> <p>When interviewed on 7/3/12 at 12:45 p.m., the Executive Director indicated he</p>						

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 07/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>had reported the event to the local Police Department.</p> <p>When interviewed on 7/3/12 at 2:10 p.m., CNA#4 indicated she usually works the 2:00 p.m. - 10:00 p.m. shifts. The CNA indicated the only visitor she has seen visiting the resident was a male visitor. The CNA stated the name of the visitor. CNA#4 indicated she has observed the visitor lying in bed with the resident "spooning" and cuddling up. The CNA described this as seeing both residents lying in bed side by side. The CNA indicated approximately 3 weeks ago she went to check on the resident after the visitor left and the resident did not have any pants or brief on. The CNA indicated she had also observed the same on numerous other occasions. CNA#4 indicated the resident was not able to remove her pants and brief on her own. The CNA indicated she had observed the resident and the visitor "spooning" in bed on several other occasions in the last couple of months. The CNA also indicated the male visitor had given the resident a shower and after the shower she observed the resident's brief and all her sheets and three pads that are on her bed were thrown out in the hallway. The CNA indicated she had reported the incidents to the nurses working but does not recall the names of the nurses. CNA</p>			

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 07/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#4 indicated she had never seen the visitor touch the resident sexually and has seen them both under the covers in bed but could not determine if they were clothed or not as they were under the covers.</p> <p>When interviewed on 7/3/12 at 2:20 p.m., CNA#3 indicated she works the evening shift. The CNA indicated she usually only sees one male visiting the resident most of the time. CNA#3 indicated "they be spoonin in bed." The CNA described this as the resident with her back to the visitor and the visitor facing her back and the male visitor having his arm across her. The CNA indicated she has seen them in bed both awake and sleeping at different times. The CNA also indicated some times the lights were off. CNA#3 indicated she had taken care of the resident after the visitor had left and when they were cleaning her up, the resident asked if there was "blood back there." The CNA indicated she had informed the nurse on duty. The CNA also indicated the resident has made statements to her such as "he is not sure if he wants to be with me or with his wife" and a lot of times the resident referred to the male visitor as her husband.</p> <p>When interviewed on 7/3/12 at 3:10 p.m., CNA#4 indicated she had additional information to add to her previous</p>			

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 07/03/2012	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>interview. The CNA indicated the resident is always cursing at the aides when they do her care and the resident has made statements such as "you just want to see my butt" or "you just want to screw me."</p> <p>When interviewed on 7/3/12 at 3:45 p.m., the facility Executive Director indicated he was completing a report to send to the Indiana State Department of Health. The written report was reviewed at this time and the report indicated CNA's were interviewed and an allegation of sexual inappropriate behaviors by Resident B's visitor was revealed.</p> <p>The facility's "Abuse Prevention, Identification & Reporting" Policy was reviewed. The policy had a revised date of 03/20/2012. The policy was provided by the Executive Director and identified as current. The policy indicated the "community staff will strive to safeguard residents from abuse, neglect, and exploitation." The policy also indicated alleged or suspected abuse was to be reported immediately to the Executive Director, Resident Care Director or other appropriate supervisory personnel. The policy also indicated staff are encouraged to report signs of resident aggressive behavior.</p>						

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 07/03/2012
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	This state residential tag relates to Complaint IN00108885.				