

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 09/24/2014
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NAME OF PROVIDER OR SUPPLIER  BROOKDALE PLACE MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8253 VIRGINIA ST MERRILLVILLE, IN 46410
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: September 23 and 24, 2014</p> <p>Facility number: 010887 Provider number: 010887 AIM number: N/A</p> <p>Survey team: Julie Ferguson, RN, TC Caitlyn Doyle, RN Heather Hite, RN Jennifer Redlin, RN</p> <p>Census bed type: Residential: 38 Total: 38</p> <p>Census payor type: Other: 38 Total: 38</p> <p>Residential Sample: 8</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on September 25, 2014, by Janelyn Kulik, RN.</p>	R000000	<p>The following is the Plan of Correction for <b>Brookdale Place Merrillville</b> in regards to the Statement of Deficiencies dated <b>09/26/2014</b>. 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 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>	
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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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R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was at least one staff member with a current first aid certificate scheduled for 8 of 42 shifts. This had the potential to affect 38 of 38 residents who reside in the facility.</p> <p>Findings include:</p>	R000117	<p><b>Corrective Action for affected/cited resident</b> No resident was affected by the alleged deficient practice. <b>How to Identify Other Residents/Associates with potential for similar</b> Audit was conducted of current associates to monitor for the presence of CPR &amp; First Aid certifications. CPR &amp; First Aid classes have</p>	10/31/2014

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R000241	<p>Review of the facility's Nursing staff schedules on 9/24/14 at 10:30 a.m., received from the Executive Director dated 8/31/14 through 9/13/14, indicated there was no staff in the facility first aid certified on the following dates/shifts:</p> <p>8/31/14-day shift 9/03/14-evening shift 9/04/14-evening shift 9/06/14-evening shift 9/07/14-evening shift 9/08/14-evening shift 9/09/14-evening shift 9/10/14-evening shift</p> <p>During an interview on 9/24/14 at 12:30 p.m., the Executive Director indicated she could not provide any documentation that a staff member on duty had a first aid certificate for the above dates.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview,</p>	R000241	<p>been scheduled so that associates will obtain first aid and CPR certification. <b>Systemic Changes you will make</b> Schedule will be posted with a notation next to associates who have been certified with CPR &amp; FA. Future classes will be scheduled as needed to keep associates updated on their certifications. <b>Monitoring Q.A. plan</b> Executive Director or designee will audit all associate CPR/First Aid certificates monthly and audit schedules prior to being posted to ensure the sufficient number of associates are scheduled per shift <b>Completion Date: 10/30/2014</b></p> <p><b>Corrective Action for</b></p>	10/30/2014			

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	<p>the facility failed to ensure medications were administered as ordered by the residents' physician for 1 of 5 residents observed for medication administration. (Resident #3)</p> <p>Findings include:</p> <p>During an observation of a morning medication administration on 9/23/14 at 9:15 a.m., LPN #1 prepared Resident #3's medications, which included Coreg (a heart medication) 6.25 mg (milligrams), Valsartan (a blood pressure medication) 80 mg, Nexium (a medication used to reduce stomach acid) 40 mg, Vitamin C 1000 mg, Multivitamin tab, Calcium Carbonate 600 mg with Vitamin D, and Aspirin 325 mg.</p> <p>During an interview with LPN #1 at 9:17 a.m. on 9/23/14, she indicated the Medication Administration Record (MAR) indicated an order for Vitamin C 500 mg daily, the dose on hand was Vitamin C 1000 mg, and the tablets were not scored. She further indicated she would ask the resident about the discrepancy.</p> <p>LPN #1 brought the prepared medications to Resident #3's room and administered all of the medications except the Vitamin C 1000 mg. LPN #1 asked Resident #3</p>		<p><b>affected/cited resident</b> No harm came to the resident as a result of the alleged deficient practice. The proper dose of the medication was obtained as ordered. <b>How to Identify Other Residents/Associates with potential for similar</b> Health &amp; Wellness Director or designee will review other residents' orders in order to determine other resident might be effected <b>Systemic Changes you will make</b> All nurses will be re-educated in the following: guidelines for medication administration, medication administration record documentation, how to handle a medication error, medication availability and receiving medication. <b>Monitoring Q.A. plan</b> The Health and Wellness Director or designee will monitor 1 med pass per shift for the next 6 months then quarterly thereafter. <b>Completion Date: 10/30/2014</b></p>				

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	<p>about the discrepancy and Resident #3 indicated she took the Vitamin C 1000 mg every other day and "that makes it up".</p> <p>LPN #1 did not administer the Vitamin C 1000 mg to Resident #3. LPN #1 signed the MAR and circled the Vitamin C medication as not given. LPN #1 noted on the back of the MAR "held vit (vitamin), dosage in bottle is wrong."</p> <p>Resident #3's record was reviewed on 9/23/14 at 10:20 a.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus.</p> <p>The Physician's Orders, dated 9/2014, indicated an order for Cymbalta (an antidepressant medication) 30 mg every other day at 8 a.m. and Vitamin C 500 mg daily.</p> <p>Review of the Medication Receipt from Resident/Family form dated 9/7/14 indicated the facility had received Vitamin C 1000 mg tabs.</p> <p>Review of the MAR, dated 9/2014, indicated the resident was to have received the Cymbalta medication on 9/23/14 at 8 a.m.</p> <p>During an interview with LPN #1 at</p>						

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	<p>12:35 p.m. on 9/23/14, she indicated she had called the Physician regarding the Vitamin C dosage discrepancy and was waiting for a response. She further indicated she had missed the Cymbalta and had not given the medication as ordered.</p> <p>During an interview with the Interim Health and Wellness Coordinator at 2:05 p.m. on 9/23/14, she indicated the resident's daughter provided her medications. She further indicated staff should have noticed the Vitamin C dosage the resident's daughter brought in was different from what the Physician had ordered and notified the Physician.</p> <p>A facility policy titled, "Medication &amp; Treatment-General Guidelines for Medication Administration/Assistance", dated 11/2011, and received as current from the Interim Health and Wellness Director, indicated, "...5. Medication directions on the pharmacy label should correlate with the medication directions on the MAR...23. Medications are to be given only within the parameters of the physician's order..."</p> <p>A facility policy titled, "Medications &amp; Treatments-Labeling Policy", dated 7/1/2010, and received as current from the Interim Health and Wellness Director,</p>			

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R000242	<p>indicated, "...The label should be consistent with a physician's order..."</p> <p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on observation, interview and record review, the facility failed to observe for effects of medication, related to monitoring a pulse for a resident on digoxin (heart medication) for 1 of 5 residents observed for medication administration. (Resident #9)</p> <p>Findings include:</p> <p>During an observation of a morning medication administration on 9/23/14 at 9:26 a.m., LPN #1 prepared and administered Resident #9's medications, which included digoxin 0.125 mg (milligrams). LPN #1 did not monitor the resident's pulse prior to the administration of the digoxin.</p> <p>Resident #9's record was reviewed on</p>	R000242	<p><b>Corrective Action for affected/cited resident.</b> Resident was not affected by the alleged deficient practice. Nurse contacted physician who gave orders for pulse daily. No parameters for notification. Would like log of pulses sent to him at next appointment. <b>How to Identify Other Residents/Associates with potential for similar.</b> Health &amp; Wellness Director or designee will audit other residents' medication and treatment orders in order to determine if other residents had orders for digoxin without physician orders to monitor pulse prior to administration. <b>Systemic Changes you will make</b> No system changes will be made unless in accordance with physician's orders. <b>Monitoring Q.A. plan</b> Health and Wellness Director or designee will audit</p>	10/31/2014

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	<p>9/24/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, hypertension, congestive heart failure, and Alzheimer's disease.</p> <p>The resident's current Physician's Orders, dated 9/2014, indicated an order for digoxin 0.125 mg, one tablet every day.</p> <p>During an interview on 9/24/14 at 10:25 a.m., the Interim Health and Wellness Coordinator indicated staff would only check the pulse if there was a Physician's order to take the pulse. She indicated there was not a current order to check the pulse prior to administration of the medication. She further indicated the digoxin order should have been checked with the Physician on to see if the Physician wanted the pulse monitored.</p> <p>The facility's medication manual, identified as current by the Interim Health and Wellness Coordinator, titled, "Nursing 2013 Drug Handbook," indicated, "Digoxin...Administration...Before giving drug, take apical-radial pulse for 1 minute. Record and notify prescriber of significant changes..."</p>		<p>the medication administration records on a monthly basis ongoing <b>Completion Date: 10/30/2014</b></p>				

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R000273	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to store and prepare foods in accordance with safe food handling standards related to the use of non-pasteurized eggs and expired refrigerated foods. This had the potential to affect all 38 residents who receive food from the kitchen.</p> <p>Findings include:</p> <p>During the observation of the kitchen on 9/23/14 beginning at 9:05 a.m. with the Dining Services Coordinator (DSC), the following was observed:</p> <ol style="list-style-type: none"> <li>1. There was a large carton of non-pasteurized eggs in the refrigerator.</li> <li>2. The following leftovers were stored in the refrigerator: <ol style="list-style-type: none"> <li>a. Oranges dated 9/10/14</li> <li>b. Pudding dated 9/15/14</li> <li>c. Fruit cocktail dated 9/18/14</li> <li>d. Beef and noodles dated 9/18/14</li> </ol> </li> </ol>	R000273	<p><b>Expired Food: Corrective Action for affected/cited resident.</b> No resident was affected by the alleged deficient practice. <b>How to Identify Other Residents/Associates with potential for similar.</b> No resident was affected by the alleged deficient practice. <b>Systemic Changes you will make</b> All expired foods found during survey was disposed of immediately. <b>Monitoring Q.A. plan</b>Dining Service Coordinator or designee will audit for expired food daily. Executive Director will monitor for expired food three times per week for the next quarter. <b>Completion Date: 10/30/2014</b></p> <p><b>Pasteurized eggs: Corrective Action for affected/cited resident.</b> No resident was affected by the alleged deficient practice. <b>How to Identify Other Residents/Associates with potential for similar.</b> No resident was affected by the alleged deficient practice. <b>Systemic Changes you will make</b> Dining Service Coordinator will continue</p>	10/30/2014

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	<p>During an interview with the DSC at the time of the observation, she indicated the eggs were used for breakfast that morning and the facility should only use pasteurized eggs. Further indicated, once refrigerated leftovers are stored and dated, they should be discarded after three days and the above items should have all been discarded.</p> <p>During an interview with the Executive Director (ED) on 9/23/14 at 11:25 a.m., she indicated there was no specific facility policy regarding pasteurized eggs "because only pasteurized eggs should be used."</p>		<p>to order eggs from the appropriate vendor in order to ensure that only pasteurized eggs are purchased. If eggs are purchased from a local store, DSC will ensure that non-pasteurized eggs are not purchased. <b>Monitoring Q.A. plan</b> Dining Service Coordinator will monitor eggs to ensure that they are pasteurized. <b>Completion Date: 10/30/2014</b></p>				