

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 09/09/2014
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NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN 46350
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: September 8 & 9, 2014</p> <p>Facility number: 010890 Provider number: 010890 AIM number: N/A</p> <p>Survey team: Heather Tuttle, RN-TC Cynthia Stramel, RN Yolanda Love, RN 9/8/14</p> <p>Census bed type: Residential: 111 Total: 111</p> <p>Census payor type: Other: 111 Total: 111</p> <p>Sample: 11</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on September 12, 2014, by Janelyn Kulik, RN.</p>	R000000		

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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R000241	<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.</p> <p>Based on record review and interview, the facility failed to ensure Physician orders were followed as written related to an antibiotic being initiated in a timely manner for a resident diagnosed with a urinary tract infection for 1 of 8 residents reviewed for Physician orders in the sample of 11. (Resident #5)</p> <p>Findings include:</p> <p>The record for Resident #5 was reviewed on 9/8/14 at 10:20 a.m. The resident's diagnoses included, but was not limited to, Alzheimer's dementia.</p> <p>A communication form dated 5/7/14, was faxed to the Physician and indicated the resident had increased irritability and was having hallucinations that morning. The Physician ordered a psychiatric consultation on 5/8/14.</p> <p>A Nursing Note dated 5/20/14, at 9:30 a.m., indicated the resident's family had returned the consent form for the</p>	R000241	<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. R241 410 IAC 16.2-5-4 (e) (1) Health Services Offense Corrective Actions accomplished for those residents found to have been affected by the deficient practice. Resident # 5 record will be review by the Wellness Director/designee to ensure physician orders were followed. Licensed</p>	10/08/2014

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	<p>psychiatric consultation, the psychiatric group had been notified, and they were awaiting a response from them.</p> <p>A Nursing Note note dated 5/23/14, at 10:05 a.m., indicated the resident was having, "...distressing active hallucinations...extremely delusional and staff not able to redirect." There was no response from the psychiatric group at that time. The Physician was notified of the resident's condition and ordered the resident to be sent to the hospital for evaluation.</p> <p>On 5/23/14 at 1:27 p.m., the hospital called the facility and indicated the resident had a urinary tract infection and would be returning to the facility. The Physician was notified, and ordered Ativan (an anti-anxiety medication) 0.5 milligrams (mg) to be given every 12 hours as needed until the psychiatric consultation was completed.</p> <p>The resident returned with a prescription for Cipro (an antibiotic) 500 mg twice daily for seven days. A Nursing Note on 5/23/14, at 2:10 p.m., indicated "Pharmacy notified of need for Ativan and Cipro delivery STAT (as soon as possible)."</p> <p>The Medication Administration Record</p>		<p>Nurses and QMA's will be re-inserviced on the following per Health and Wellness Director: A. Timely response to Physician Orders. B. Documentation guidelines in the Nursing Notes- including initiation of antibiotics and response to treatment.</p> <p>How to Identify Other Residents/Associates The Health and Wellness Director/designee will continue to review the Observation and Monitoring/24-Hour report daily, identifying residents with change of condition and ensuring that implementation of prescribed orders is documented. This review is ongoing.</p> <p>Systemic Changes Five residents' medication administration reviews will be performed weekly per Health and Wellness Director/designee to ensure that orders are addressed as prescribed per physician and documented in the resident record accordingly. This review is ongoing. Monitoring Q.A. The Health and Wellness Director/designee is responsible for monitoring compliance of physician orders and documentation in the resident's record. As part of the community's monthly Continuous Quality Improvement meetings, the</p>				

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R000349	<p>(MAR) for May 2014 indicated Ativan .5 mg was initiated on 5/23/14 at 7:00 p.m. The MAR indicated the Cipro was not initiated until 5/27/14, four days later. There was no documentation in the Nursing Notes when the antibiotic had been initiated.</p> <p>Interview with the Director of Nursing (DON) and RN #1, on 9/8/14, at 11:40 a.m., the DON indicated the Pharmacy should have delivered the medications the same day if it was a STAT order. RN #1 did not know why the Cipro was delayed, but indicated four days was not an acceptable time frame.</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. Based on record review and interview, the facility failed to ensure the resident's clinical record was accurate and complete related to documentation and indication for use of antipsychotic, antianxiety, and antidepressant medications for 3 of 8</p>	R000349	<p>agenda will include community measures of monitoring activities of physician orders and documentation compliance completed by the Health/Wellness Director/designee. This measurement of compliance will continue until compliance is met. The Executive Director is responsible for enforcement of this regulation. The facility is asking for paper compliance Completion Date: October 8th 2014.</p> <p>R349 410IAC 16.2-5-8.1(a)(1-4) Clinical Record Non-Compliance Corrective Actions accomplished for those residents found to have been affected by the deficient practice. Resident # 4 and</p>	10/08/2014			

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	<p>residents reviewed for medications in the sample of 11. (Residents #4, #7, and #11)</p> <p>Findings include:</p> <p>1. The record for Resident #11 was reviewed on 9/8/14 at 1:40 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, stroke, Alzheimer's dementia, and weakness.</p> <p>Review of Nursing Progress Notes dated 5/6/14, indicated the resident was attempting to assist another resident and lost her footing and twisted her right wrist, but indicated she was ok. The next documented entry in Nursing Progress Notes was on 7/30/14 which indicated the Podiatrist was there. The next documented entry in Nurse's Notes was dated 8/25/14 at 10:40 a.m., which indicated "Fax to MD (name) requesting assist with resident not eating well, all she wants to do is sleep, depressed. States 'All she wants to do is go home'- (meaning pass)." The next documented entry was on 8/25/14 at 2:33 p.m., which indicated "N.O. (New Order) received Remeron (an antidepressant medication) 7.5 milligrams (mg) by mouth at night time...."</p>		<p>resident # 11 medical records will be review by the Wellness Director/designee to ensure the resident's clinical records is accurate and complete related to documentation and indication for use of antipsychotic, antianxiety, and antidepressant medication. Resident # 7 was discharged from the community. Licensed Nurses and QMA's will be re-inserviced on the following per Health and Wellness Director: A. Indication of Drug Use-including Anti-psychotics, Anti-anxiety and Anti-depressants B. Policy on Psychotropic Monitoring How to Identify Other Residents/Associates The Health and Wellness Director/designee will continue to review the Observation and Monitoring/24-Hour report daily to ensure that new orders for antipsychotics, anti-anxiety and anti-depressants have an indication for use documented in the resident's record. This review is ongoing. Systemic Changes Five resident's record reviews will be performed weekly per Health and Wellness Director/designee, ensuring indication for use is documented in the resident's record for residents receiving antipsychotics, anti-anxiety</p>				

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	<p>Continued record review indicated there was no other documentation of any other instances when the resident was not sleeping, eating, or would not come out of her room.</p> <p>Interview with the Memory Care Program Director on 9/8/14 at 2:00 p.m., indicated there was no other documentation of the resident's signs or symptoms of depression. She further indicated the Memory Care Unit did not have a behavior book with a list of residents and their behaviors and interventions.</p> <p>2. The record for Resident #7 was reviewed on 9/8/14 at 12:54 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, Alzheimer's dementia, depression, and anxiety.</p> <p>Review of Nursing Progress Notes dated 5/23/14 at 2:00 p.m., indicated "Spoke to POA (Power of Attorney) (name) and he stated, 'Don't give my wife any Ativan (an antianxiety medication) until Tuesday when we can speak with the Physician (name) about Risperidone (an antipsychotic medication) orders. It makes her way too sleepy and she could fall and she is now eating better too.'"</p>		<p>and anti-depressants, until compliance is met. This review is ongoing. Monitoring Q.A. The Health and Wellness director/designee is responsible for ensuring that residents receiving antipsychotics, antianxiety and antidepressants have the indication for use documented in the resident's record. As part of the community's <u>monthly</u> Continuous Quality Improvement meetings the agenda will include discussion on compliance with indication for use for antipsychotics, antianxiety and antidepressants, until compliance is met. The Executive Director is responsible for enforcement of this regulation. The facility is asking for paper compliance. Completion Date: October 8, 2014.</p>				

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	<p>Review of fax communication form dated 5/24/14 indicated "Family refused routine Ativan can we increase Risperdal .25 milligrams (mg) to BID (twice daily) or TID (three times a day). She does exhibit increased anxiety and pacing." The Physician's response dated 5/25/14 indicated "Start with BID."</p> <p>Review of Physician Orders dated 5/16/14 indicated Risperdal .25 mg every morning. The new order dated 5/27/14 indicated Risperdal .5 mg BID.</p> <p>Continued review of Nursing Progress Notes for the month of May 2014 indicated there was no evidence the resident had increased anxiety to warrant the increase of the antipsychotic medication.</p> <p>Interview with the Memory Care Program Director on 9/8/14 at 2:00 p.m., indicated there was no other documentation of the resident's increased anxiety or an indication for the use of the Risperdal medication. She further indicated the Memory Care Unit did not have a behavior book to monitor the resident's behaviors.</p> <p>3. The record for Resident #4 was reviewed on 9/8/14 at 11:00 a.m. The resident's diagnoses included, but were</p>			

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	<p>not limited to, Alzheimer's dementia, depression and insomnia.</p> <p>Review of Physician Orders dated 5/12/14 indicated Seroquel (an antipsychotic medication) 50 milligrams (mg) one tab at night time. Further review of Physician Orders dated 2/20/14 indicated the resident was receiving Xanax (an antianxiety medication) .25 mg BID (twice daily).</p> <p>Review of a fax communication form dated 5/14/14, indicated "Receiving Seroquel 50 mg at night time. Seems to be a little too much. Can we try Seroquel 25 mg at night time?" The Physician's response dated 5/16/14 indicated "Yes."</p> <p>Review of Nursing Progress Notes dated 7/5/14 at 11:00 a.m., indicated the resident was not in a good mood this morning somewhat sarcastic. Her mood improved as the shift progressed. Prior to 7/5/14, Nursing Progress Notes had no evidence of any documentation in the months of May and June 2014 of any kind of behaviors.</p> <p>The next documented entry in Nursing Progress Notes was dated 7/15/14, at 8:50 a.m., indicated "At 8:00 AM CNA came to me and states (resident name) is cursing, abusive ect. due to time for</p>			

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	<p>shower. I went in to assist resident, continue with abusive language and hitting at staff, staff standing out of resident space, when resident got self out of bed started to swing at the staff she scratched her right forearm causing a small skin tear. Resident stumbled backward and hit her back and arm against the wall corner next to her bed. Resident assist initiated she continued to yell and curse. Staff not in resident space. Nurse came in and resident took meds freely. This writer left the apartment to update Physician."</p> <p>Review of a fax communication sheet dated 7/15/14 indicated the resident was having increased behaviors in the morning with verbal and physical aggression. The Nursing staff had asked the Physician if the Seroquel medication could be increased to 50 mg again and also suggested a low dose of Seroquel during the day. The Physician responded on 7/15/14 with Seroquel 50 mg at night time and Seroquel 25 mg 1/2 tab in the morning and afternoon.</p> <p>Review of Physician's Orders dated 7/15/14 indicated "Seroquel 50 mg at night time. Diagnosis Insomnia."</p> <p>Review of Physician's Orders dated 7/15/14, indicated "Seroquel 25 mg 1/2</p>						

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	<p>tab in the morning and afternoon. Diagnosis Insomnia."</p> <p>Continued review of Nursing Notes dated 8/23/14, at 10:30 a.m., indicated resident yelling at staff for her car. Resident left alone and monitored by staff. Pacing and holding her back. Offered as needed pain meds, resident refused.</p> <p>Nurse's Notes dated 8/26/14, at 4:45 p.m., indicated the resident was angry and pacing watching the elevator. She refused her medications.</p> <p>Nurse's Notes dated 8/28/14 at 10:20 a.m., indicated the resident's Physician was updated regarding increased angriness, increased pacing and appears to have increased pain. Further review of Nurse's Notes dated 8/28/14 at 3:00 p.m., indicated new order to increase Xanax to .5 mg BID.</p> <p>Review of the Medication Administration Record (MAR) for the month of August 2014 indicated an order for Naproxen (an non steroid anti inflammatory medication used to reduce pain) 220 mg 2 tabs as needed three times a day. Further review of the MAR indicated the Naproxen had not been signed out as given the entire month of August 2014.</p>						

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R000407	<p>Interview with the Memory Care Program Director on 9/8/14 at 2:00 p.m., indicated there was no diagnosis for the Seroquel medication. She further indicated there was no continued documentation of the resident's behaviors to support the increases of the Seroquel and the Xanax.</p> <p>Interview with the Director of Nursing on 9/9/14 at 10:00 a.m., indicated the facility did not have a current policy regarding the use of psychotropic medication.</p> <p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on record review and interview, the facility failed to ensure each resident received the influenza vaccination for 2 of 8 residents reviewed in the sample of 11. (Residents #3 and #11)</p> <p>Findings include:</p>	R000407	R407 410IAC 16.2-5-12(b)(1-4) Infection Control- Noncompliance Corrective Actions accomplished for those residents found to have been affected by the deficient practice. Resident # 3 and Resident # 11 is schedule to receive flu vaccination on	10/08/2014			

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	<p>1. The record for Resident #3 was reviewed on 9/8/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, dementia.</p> <p>A Physician's Order dated 8/11/11 and on the current Physician 9/2014 recap indicated "May have annual influenza vaccine."</p> <p>Review of the immunization record indicated the last documented influenza vaccination the resident received was in 2012. There was no evidence the resident received a flu vaccine in 2013.</p> <p>Review of Nursing Progress Notes dated 10/2013 and 11/2013 indicated there was no evidence the resident received a flu vaccination in those months.</p> <p>Interview with the Memory Care Program Director on 9/9/14 at 1:00 p.m., indicated the facility had an outside agency come into the facility to administer the flu vaccines, however, the resident's name was not on the list. She further indicated, she had contacted Hospice to see if they had administered the flu vaccine to the resident, in which they indicated they had not done so.</p> <p>2. The record for Resident #11 was</p>		<p>October 7th 2014. Licensed Nurses and QMA's will be re-inserviced on the following per Health and Wellness Director: A. Documentation of the influenza administration on the Immunization Record and service notes located in the residents record. This documentation will include whether residents were offered or a declination to receive influenza administration was received. How to Identify Other Residents/Associates The Health and Wellness Director/designee will maintain a flu roster on all residents receiving influenza injections as well as ensure that documentation in the services notes is present. Systemic Changes Five resident's weekly record reviews will be performed per Health and Wellness Director/designee, ensuring immunization records and service notes are current. Monitoring Q.A. Through random record reviews the Health and Wellness director/designee is responsible for ensuring that Immunization Records are maintained in the residents' record and documentation of influenza administration or declination is in the service notes. This task is ongoing. As part of the community's</p>				

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	<p>reviewed on 9/8/14 at 1:40 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia.</p> <p>Review of a fax communication sheet dated 10/6/13, indicated "Is it ok for Res. (Resident) to have annual flu vaccine? Flu vaccine due 10/9/13." The Physician's response was delivered via fax on 10/7/13 which indicated "Give flu vaccine."</p> <p>Review of Nursing Progress Notes dated 10/2013 and 11/2013 indicated there was no evidence the resident received a flu vaccination in those months.</p> <p>Interview with the Memory Care Program Director on 9/9/14 indicated the resident was not on the agency's list of residents who they had administered the flu vaccine to.</p> <p>Interview with the Director of Nursing on 9/9/14 at 1:15 p.m., indicated the facility had no policy or procedure regarding flu vaccinations.</p>		<p>monthly Continuous Quality Improvement meetings the agenda will include discussion of influenza administration documentation, until compliance is met.</p> <p>The Executive Director is responsible for enforcement of this regulation. The facility is asking for paper compliance.</p> <p>Completion Date: October 8, 2014.</p>				