

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 10/22/2014
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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 the Post Survey Revisit (PSR) to the State Licensure survey completed on 9/9/14.</p> <p>This visit was done in conjunction with the Investigation of Complaint IN00156929.</p> <p>Survey date: October 22, 2014</p> <p>Facility number: 010890 Provider number: 010890 AIM number: N/A</p> <p>Survey team: Heather Tuttle, RN, TC Cynthia Stramel, RN</p> <p>Census bed type: Residential: 106 Total: 106</p> <p>Census payor type: Other: 106 Total: 106</p> <p>Sample: 6</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on October 26,</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>2014, by Janelyn Kulik, RN.</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.</p> <p>Based on record review and interview, the facility failed to ensure Physician Orders were followed as written related to medication administration for 1 of 3 residents reviewed for medication administration in the sample of 6. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 10/22/14, at 10:20 a.m. The resident's diagnoses included, but were not limited to, non insulin dependent diabetes mellitus, anxiety, and depressive disorder.</p> <p>Review of the discharge instructions from the hospital dated 6/16/14 indicated the resident's diagnosis was an urinary tract infection. The resident was to follow up with her Primary Care</p>	R000241	<p>This plan of Correction is not to be construed as admission of or agreement with the findings</p> <p>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>R 241 Physician Orders R241-410IAC 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# B record will be</p>	11/20/2014

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	<p>Physician in one week on 6/23/14. Further review of the discharge instructions indicated the resident was to continue glimepiride (Amaryl, a medication used to lower blood glucose levels) 1 milligram (mg) everyday.</p> <p>Review of the Healthcare Provider Communication Form dated 6/24/14 and completed by the resident's Primary Care Physician indicated the resident was to continue Vitamin D 50,000 units every week. There were no other medication clarification or new orders noted by the Physician.</p> <p>Review of the Healthcare Provider Communication Form dated 5/27/14 and completed by the resident's Primary Care Physician indicated the resident should be on glimepiride 1 mg everyday and not prn.</p> <p>Review of the Medication Administration Record (MAR) for the months of 6/2014, 7/2014, 8/2014, and up until 9/17/14 indicated the glimepiride 1 mg was administered everyday to the resident.</p> <p>Review of a prescription faxed on 9/17/14 from a pharmacy the resident had used and not the facility's pharmacy indicated glimepiride 1 mg tablet, take 1 tablet everyday prn (as needed) if glucose</p>		<p>reviewed by the Wellness Director/designee to ensure Physician Orders were followed as written related to medication administration. Nurses and QMA's who were responsible for this deficiency will be counseled for not following Physician orders. Nurses and QMA's will be re-in serviced on the following per Health and Wellness Director A. Timely response to Physician Orders.</p> <p>B. timely notification of new orders, change orders and change of condition.</p> <p>How to Identify Other Residents/Associate .</p> <p>The Health and Wellness Director/designee will continue to review the Observation and Monitoring 24-hour report, new orders, change of orders and timely notification will be review daily to ensure compliance. Nurses and QMA's will be re-in serviced on the following per Health and Wellness Director A. Timely response to Physician Orders.</p> <p>Systematic Changes</p> <p>Five resident's medication administration and new orders 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.</p> <p>Monitoring QA</p> <p>The Health and Wellness</p>				

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	<p>was >(greater than) 130. The original order date on the faxed prescription was dated 6/23/14.</p> <p>Review of Nurse's notes dated 9/17/14 at 10:00 p.m., indicated "Order clarification received from pharmacy (name) for glimepiride 1 mg take 1 tablet everyday if glucose >130. MAR updated."</p> <p>Interview with the LPN #1 on 10/22/14 at 2:45 p.m., indicated she was unaware of the order change for the glimepiride. She indicated she works the front hall and usually a QMA passes the morning medications where the resident had lived. She further indicated she would call the Pharmacy and see if the prescription was a clarification from the Physician, a new order from the Physician, or a refill from the Pharmacy.</p> <p>Continued interview with LPN #1 on 10/22/14 at 3:00 p.m., indicated she called the Pharmacy and they indicated it was a refill, in which they had received the prescription from the Physician. The LPN further indicated she then called the resident's Physician and he had left for the day, but the nurse in the office looked in the resident's record and pulled out a list of her current medications. The summary report of the resident's medications indicated glimepiride 1 mg</p>		<p>Director/Designee is responsible for monitoring compliance of physician orders, notification and documentation in the resident's record. As part of the community's monthly Continuous Quality Improvement meetings, the agenda will include community measure 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. Completion Date: November 20th 2014.</p>				

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	<p>take 1 tablet everyday prn glucose >130. The start date for the medication was dated 6/23/14.</p> <p>Review of the June 2014 Blood Glucose Tracking record indicated the resident should have only received the glimepiride on 6/29/14 when her blood glucose was 140. The resident's blood glucose levels from 6/23-6/28, and 6/30/14 were all below 130.</p> <p>Review of the July 2014 Blood Glucose Tracking record indicated the resident should have only received the glimepiride on 7/5-136, 7/14-136, 7/17-132, and 7/25-190. The rest of the month the resident's blood glucose was below 130.</p> <p>Review of the August 2014 Blood Glucose Tracking record indicated the resident should have only received the glimepiride on 8/2-132, 8/22-137, 8/23-131, 8/25-133, 8/28-136, and 8/30/14-144. The rest of the month the resident's blood glucose was below 130.</p> <p>Review of the September 2014 Blood Glucose Tracking record indicated the resident should have only received the glimepiride on 9/4-131, 9/7-142, 9/10-132, 9/11-134, 9/14-140 and 9/17/14-132.</p>						

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	<p>Review of the 9/2014 MAR from 9/18-9/30/14 indicated the resident received the glimepiride 1 mg on 9/23/14.</p> <p>Review of the 10/2014 from 10/1-10/22/14 indicated the resident received the glimepiride 1 mg on 10/6, 10/9, 10/10, 10/12, 10/13, and 10/16-10/19/14 all for blood glucose levels >130.</p> <p>Interview with the Director of Nursing (DoN) on 10/22/14 at 3:15 p.m., indicated the facility was unaware of the change in the prescription from the Physician.</p> <p>Interview with LPN #2 on 10/22/14 at 3:15 p.m., indicated she was the nurse that received the order from the Pharmacy and changed the order on the 9/2014 MAR, however, she indicated she did not call the resident's Primary Care Physician to ensure it was correct.</p>			