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 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT LAPORTE	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
R000000	This visit was for the Investigation of Complaint IN00162915. Complaint IN00162915- Substantiated. State deficiency related to the allegation is cited at R0036. Survey date: February 6, 2014 Facility number: 010890 Provider number: 010890 AIM number: N/A Survey team: Janet Adams, RN, TC Census bed type: Residential: 108 Total: 108 Census payor type: Other: 108 Total: 108 Sample: 3 This State Residential finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on February 9, 2015, by Janelyn Kulik, RN.	R000000	The following is the Plan of Correction for **Brentwood at LaPorte** in regards to the Statement of Deficiencies dated 2/6/15. 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. The facility is requesting a desk review for compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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R000036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on observation, record review, and interview the facility failed to notify the attending Physician and Responsible Party of the Emergency Room orders for treatments and follow up appointments for 2 of 3 resident's reviewed with recent Emergency Room visits. The facility also failed to notify the Physician of lack of continued leg edema after an Emergency room visit for 1 of 3 residents reviewed for recent Emergency Room visits in the sample of 3. (Residents #B and #C) Findings include: 1. The record for Resident #C was	R000036	**Violation Plan of Correction** 410 IAC 16.2-5-1.2(k)(1-2) Resident's Rights-deficiency 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.	02/19/2015

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	reviewed on 2/6/15 at 9:07 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, gout, depressive disorder, and chronic kidney disorder. The resident was sent to the Emergency Room on 1/9/15 and returned to the facility on the same day. The 1/9/15 Emergency Room records were reviewed. The Discharge Instruction sheet indicated the resident's discharge diagnoses were acute UTI (Urinary Tract Infection) and generalized weakness. The resident was given a prescription in the Emergency Room for Bactrim 400 milligrams-80 milligrams (an antibiotic) for three days. Follow up instructions were to follow up with her Primary Physician in two days on 1/11/15. The 1/9/2015 Service Notes were reviewed. An entry made on 1/9/15 at 6:30 p.m. indicated the resident returned from the Emergency Room with new orders for an antibiotic to be given to treat a UTI . The entry also indicated the Pharmacy was called and the POA (Power of Attorney) was made aware of the above order. There was no documentation of the resident's attending Physician having been notified of the resident's diagnosis, prescription for the antibiotic, or the Emergency instructions		**1.Res. C- Primary physician was notified, but this was not initially documented. An appointment was scheduled on 1/12/15 by the staff member. The initial appointment was scheduled to be 1/26/15. Due to inclement weather, this appointment had to be rescheduled to 2/13/15.** **Res. B- Primary physician was notified regarding resident status on 2/6/15 and the order for PRN (as needed) Lasix was discontinued.** **2.An audit of discharges to the hospital that occurred in the past 30 days was completed by the Health and Wellness Director and designee on 2/12/15. No other residents were noted to be adversely affected.** **1.Nursing staff to be re-educated by the Licensed Nurse Designee regarding physician and responsible party notification using the existing Change of Condition policy as a guideline.** **·The Licensed Nurse (DON/HWD/RCD) or designee to perform record review audit on residents who leave the assisted living community upon returning from the hospital.** **·These audits will be performed within 24 business hours of return from hospital.**	

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	to follow up with the attending Physician in two days. The was no documentation of the resident's Responsible Party being notified of the need for any follow up appointments. There were no further entries on 1/9/15. The 1/10/15 and 1/11/15 Service Notes were reviewed. There was no documentation of the resident's Primary Physician being notified of the need for follow up as per the Emergency Room discharge instructions. There was no documentation of the resident's POA being notified of the need for a follow up appointment. When interviewed on 2/6/15 at 10:00 a.m., the Assistant Wellness Director indicated the protocol was for staff to call the Primary Physician when a resident returned from an Emergency Room visit with new orders to verify if the Physician wanted the resident to be seen for a follow-up appointments or if there any further instructions. 2. On 2/6/15 at 10:50 a.m., Resident #B was observed sitting in a recliner chair in his apartment. The resident's ankles, feet, and lower legs appeared swollen. The record for Resident #B was reviewed on 2/6/15 at 8:55 a.m. The resident's		**·Audits will continue to be performed for a period of 6 months or longer until a pattern of substantial compliance is achieved.** **1.QA Committee will review audit findings monthly for a period of 6 months or until a pattern of substantial compliance is achieved. The Executive Director will be responsible for directing additional corrective actions based on audit findings.** **5. Completion date: 2/19/15**	

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	diagnoses included, but were not limited to, Alzheimer's disease, benign prostatic hypertrophy, and a history of a pulmonary embolism (a blood clot in the lung). The resident was sent to the hospital Emergency Room on 1/20/15 and returned to the facility the same day. The 1/20/15 Emergency Room records were reviewed. The resident's discharge diagnosis was noted as edema (swelling). The Discharge Instruction sheet indicated the resident was to take Lasix (a diuretic medication) two times a day and follow up with his Primary Physician in two days. The 1/2015 Medication Administration Record was reviewed. The resident had been receiving Lasix 40 milligrams once a day 1/1/15 through 1/20/15. The Medication Administration Record also indicated the Lasix was increased to twice a day on 1/21/15. The 1/2015 Service Notes were reviewed. An entry made on 1/20/15 at 8:00 a.m. indicated the resident had non-pitting edema to his bilateral lower extremities. The Physician was notified and orders were received to send the resident to the hospital Emergency Room. The next entry was made at 6:00 p.m. This entry indicated new orders were obtained from			

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	the Emergency Room to increase the resident's Lasix to 40 milligrams twice a day and to follow up with the Primary Physician in two days. There was no documentation of the resident's Primary Physician being notified of the resident's return from the Emergency Room, the new orders to increase the Lasix, or the need for a follow up appointment. An entry made on 1/21/15 at 12:00 p.m. indicated the resident had +4 non pitting edema to the his bilateral lower extremities. An entry made on 1/22/15 at 9:00 p.m. indicated +4 edema was noted to the resident's feet. An entry made on 1/23/15 at 5:00 a.m. indicated the resident had +4 edema present to the bilateral lower extremities. When interviewed on 2/6/15 at 10:00 a.m., the Assistant Wellness Director indicated the protocol was for staff to call the Primary Physician when a resident returns from an Emergency Room visit with new orders to verify if the Physician wanted the resident to be seen for a follow-up appointments or if there any further instructions. When interviewed on 2/6/15 at 11:00 a.m., the Assistant Wellness Director indicated the resident continued to have edema to the lower extremities after the			

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	Emergency Room Physician increased the dose of the Lasix. The Assistant Wellness Director also indicated the resident's Primary Physician should have been notified of the increase in the Lasix and the need for any follow up appointment. The Director also indicated the Physician had not been notified of the continuing edema after the increase in the Lasix. The facility policy titled "Change in Condition/Notification" was reviewed on 2/6/15 at 9:45 a.m. The Policy had a reviewed date of 10/16/14. The policy indicated the the resident, resident's Physician, and the legal representative or responsible party were to be notified of any accident This State Residential tag relates to Complaint IN00162915.			