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 04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MARION	2452 W KEM RD MARION, IN 46952

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00198628 and IN00198999. Complaint IN00198628 - Substantiated. State deficiency related to the allegation is cited at R0036. Complaint IN00198999 - Substantiated. No State deficiencies related to the allegations are cited. Survey dates: April 26 and 27, 2016 Facility number: 010682 Provider number: N/A AIM number: N/A Residential census: 35 Sample: 9 This deficiency reflects State findings cited in accordance with 410 IAC 16.2.5. QR completed by 11474 on May 4, 2016.	R 0000		
R 0036 Bldg. 00	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			

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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	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 interview and record review, the facility failed to notify the resident's physician when a resident fell that could result in the need to alter medication or treatment related to care for 1 of 4 resident's reviewed for physician's notification. (Resident C) Findings Include: Review of Resident C's closed clinical record began on 4/26/16 at 3:03 p.m. Diagnoses included, but were not limited to, hypertension, aortic stenosis, coronary artery disease and diabetes mellitus. Resident C's current medications included, but were not limited to, warfarin (oral anticoagulant) 2.5 mg on Monday (8/10/15), Wednesday (8/12/15) and 5 mg on Tuesday (8/11/15), Thursday (8/13/15) and Friday (8/14/15). Resident C also took aspirin 81 mg daily. The most recent Prothrombin Time (PT), dated 8/13/15, was 30.1 seconds and the International Normalized Ratio (INR)	R 0036	The 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. R0036: Corrective Action for Affected Resident: Resident no longer resides at community. How to identify other residents with potential for similar events: An audit of residents with falls was completed. No other residents were identified with same alleged deficient practice. Systematic Changes: Executive Director and Health and Wellness Director will add physician notification for falls to change of shift report for nurse coming on to audit previous shift. The community will notify the physician of change of condition	06/15/2016

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	was 2.8. A nursing note, dated 8/15/15 at 6:20 a.m., indicated a "thud" was heard from Resident C's room. LPN #1 indicated when she entered the room, Resident C was on the floor. The resident stated "she just fell." Resident C indicated her left leg hurt and she was noted to have a small scrape with no bleeding. The Health and Wellness Director was notified. Resident C was assisted to stand and ambulated to the bathroom. Nurses notes, on 8/15/15 at 7:30 a.m., Resident C stated "she was shook-up from fall." She denied any pain. At 9:00 a.m., Resident C's daughter came to visit and was notified of the fall. Nurses notes, on 8/16/15 at 6:00 a.m., Resident C was observed to have a bruise by her left eye that was slightly swollen. Resident C continued to ambulate with her walker. Nurses notes, on 8/16/15 at 2:00 p.m., Resident C informed LPN #2 that when she fell, she did hit her face. Nurses notes, on 8/17/15 at 9:20 a.m., Resident C was found to have been noncoherent, had vomited and been incontinent. Resident C was sent to the		in accordance with Brookdale policy and procedure. Clinical staff will be in-serviced on the change of condition and fall policy on April 29, 2016 and annually. Monitoring Q.A. Plan: Falls that occur will be reviewed daily in morning meeting and will be brought to the Collaborative Care meetings 2 x a month for 2 months, the Health and Wellness Director to audit falls for physician notification 5 times a week for 4 week then 1 time a week x4 weeks. Expected compliance will be on or before June 15, 2016.	

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	emergency room by ambulance. Nurses notes, on 8/19/15 at 9:15 p.m., Resident C returned to the facility under hospice care. A nursing note indicated "Res [resident] still in coma 0 [zero] response." A nursing note, dated 8/19/15 at 10:00 p.m., indicated "N.O. [new order] [name of hospice company] as hospice dx [diagnosis] subdural hematoma...." On 8/20/15 at 9:30 a.m., Resident C passed away with family at her bedside. There was no documentation in the clinical record regarding the physician being notified of the fall. During an interview on 4/27/16 at 8:52 a.m., the Health and Wellness Director (HWD), indicated she could not find any physician notification related to the fall. She indicated the staff should have notified the physician, but did continue to document there was no change in mental status or mobility. During an interview on 4/27/16 at 8:52 a.m., the HWD indicated the facility does not do neurological assessments following a fall. She indicated they would notify the physician, assess the			

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	resident and encourage them to go to the hospital. During a telephone interview on 4/27/16 at 2:56 p.m., LPN #1 indicated "it was the weekend" and she may have faxed something to the office, but she was not sure if she did. She indicated she did not think the resident needed to be sent out to the hospital. She indicated she did not call the physician. During an interview on 4/27/16 at 8:52 a.m., the HWD indicated staff do fax information to the doctor's office on the weekends and they may not get the fax until Monday. She indicated the staff can call the physician. Review of a current facility policy dated 10/2013 and revised 3/2016, provided by the HWD on 4/26/16 at 9:17 a.m., titled "Falls Management Policy" indicated the following: "Policy Overview All residents have the potential to fall. A fall is defined as any drop, collapse, or tumble. Any witnessed or reported unwitnessed fall with or without injury is reported in the Brookdale Incident Reporting System (BAIRS). Residents who sustain a fall should have a post fall investigation completed with			

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	interventions identified to reduce the potential for future falls and injury. Policy Detail 1. The Executive Director (ED) and Health and Wellness Director (HWD) are responsible.... ...5. If a fall occurs: a. Assist.... b. Notify the HWD/designee and ED. c. Notify the resident's physician/healthcare provider for evaluation, care, and treatment if indicated...." Review of a another facility policy dated 9/1/1998 and revised 4/2016, provided by the Administrator on 4/27/16 at 9:26 a.m., titled "Head Injury Policy" indicated the following: "All residents sustaining a head injury receive immediate attention for serious injury. A resident sustaining a head injury presenting with no apparent injury or minor injury and having access to healthcare providers or third-party providers have the option to use that service. Resident/Legal Representative has the right to refuse a recommendation for Emergency Room (ER) transport. Policy Detail The attached Head Injury Flowsheet....			

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	1. Resident/Legal Representative has the right to accept or refuse medical care; however the steps to ensure informed consent must be clearly documented. ...b. Notification of third party healthcare provider. c. Notification of legal representative (if indicated) and action taken (example - if refusal for ER evaluation then informed of risks and consequences with date/time indicated)...." This State tag relates to Complaint IN00198628.			