

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 10/04/2011
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NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIRCLE HOBART, IN46342
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R0000	<p>This visit was for the Investigation of Complaint IN00097162.</p> <p>Complaint IN00097162- Substantiated, state residential finding related to the allegations is cited at R0064.</p> <p>Survey dates: October 3 and 4, 2011</p> <p>Facility number: 002627 Provider number: 002627 AIM number: N/A</p> <p>Survey Team: Janelyn Kulik, RN</p> <p>Census bed type: Residential: 118 Total: 118</p> <p>Census bed type: Other: 118 Total: 118</p> <p>Sample: 6</p> <p>This state finding is cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on October 11, 2011 by Bev Faulkner, RN</p>	R0000		

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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R0064	<p>(hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on record review and interview, the facility failed to exercise reasonable care to prevent the loss of 1 of 6 residents belongings related to not locking the resident's room when she was at the hospital and allowing another resident to enter the room and knock over a cabinet. (Resident #E and #F)</p> <p>Findings included:</p> <p>The record for Resident #E was reviewed on 10/3/11 at 12:00 p.m. A nursing note, dated 8/11/11 at 3:00 a.m., indicated while the resident was running in the hall the resident fell forward with her face hitting the floor. The right side of her face had abrasions and there was blood coming from her right nostril. She was assisted up after checking range of motion and vital signs. At 3:02 a.m., the resident's guardian was explained the situation. At 3:04 a.m., the physician was given the resident's status and an order was received to send the resident out. At 3:15 a.m., transport arrived. At 3:25 a.m.,</p>	R0064	<p>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 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 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> <p>R 064 Residents Rights- Noncompliance</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p>· Resident # E physically discharged from our community on 8/30/11.</p> <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will</i></p>	10/23/2011

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	<p>the resident left the facility via stretcher. At 6:03 a.m., the resident returned to the facility with family member. The resident remained restless and was pacing in the hall at a quick pace. The family stated, "They gave her something for pain but nothing to calm her down and she is going to do it again." At 10:30 a.m., staff spoke to the resident's responsible party concerning medication increase and fragile items in the resident's room. Responsible Party will be removing more fragile items from her room within the next couple of days.</p> <p>The record for Resident #F was reviewed on 10/3/11 at 10:45 a.m. A nursing note, dated 8/11/11 at 7:00 a.m., indicated the resident had been up all night wandering and pacing. The resident wandered into other resident's room. While in Resident #E's room, she knocked over a curio cabinet and broke figurines and glass from the cabinet. No one was injured or cut.</p> <p>Interview with he Resident Care Director on 10/4/11 at 10:55 a.m., indicated Resident #F went into Resident #E's room while she was at the hospital. She knocked over a curio cabinet and broke the glass. She further indicate the facility was not responsible due to the policy and the contract the resident signs when they move into the facility. She also indicated</p>		<p><i>be taken?</i></p> <ul style="list-style-type: none"> · When a Resident is transported to the hospital related to an emergency, the charge nurse will make sure that the resident apartment is secured ensuring the door is locked. <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> · When a Resident is transported to the hospital related to an emergency, the charge nurse will make sure that the residents apartment is secured immediately upon there exit ensuring the door is locked. · The Executive Director or Designee will check the resident apartment to make sure that the doors are secured within 24 hours of the resident being transported out of the community. <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> · The Manager on Duty daily will be responsible for checking the apartments for any resident who is in the hospital or in rehab to ensure it is secured. This item will be added to their checklist. · The Manager on Duty will report and concerns to the Executive Director or designee daily. · The Executive Director or designee will follow up on and concerns within 24 hours. · The Regional team will check this during their visits at least quarterly and during the annual Comprehensive process review. <p><i>By what date will these systemic</i></p>				

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	<p>the resident's room was not locked after she was sent to the hospital.</p> <p>This Federal finding relates to Complaint IN00097162.</p>		<p><i>changes be implemented?</i></p> <p>10/23/11</p>		