

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 08/21/2014
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NAME OF PROVIDER OR SUPPLIER BROOKDALE PLACE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 2601 VALPARAISO ST VALPARAISO, IN 46383
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R000000	<p>This visit was for the Investigation of Complaint IN00154736.</p> <p>Complaint IN00154736- Substantiated. State Residential deficiency related to the allegation was cited at R0036.</p> <p>Survey Dated: August 20 and 21, 2014</p> <p>Facility number: 010757 Provider number: 010757 AIM number: N/A</p> <p>Survey team: Regina Sanders, RN-TC</p> <p>Census by bed type: Residential: 74 Total: 74</p> <p>Census Payor type: Other: 74 Total: 74</p> <p>Residential Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on August 26, 2014, by Janelyn Kulik, RN.</p>	R000000		
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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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R000036	<p>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.</p> <p>Based on record review and interview, the facility failed to immediately notify a resident's physician and responsible party of a decline in the resident's physical and mental status, related to a decrease in appetite, decline in activities of daily living (ADL's), and a change in physical/mental condition, for 1 of 3 residents reviewed for change of condition in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 08/20/14 at 12:34 p.m. The resident's diagnoses included, but were not limited to, hypertension and coronary artery disease.</p> <p>A. Resident #B's Progress Note, dated 08/08/14 at 8 p.m., indicated the resident had not eaten dinner and was not alert to</p>	R000036	<p><i>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. <u>R036 Resident Rights - Deficiency</u> What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?Resident affected by the deficient practice is no longer a resident in the community.</i></p> <p>No other residents were affected by</p>	09/08/2014

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	<p>the staff. The resident's pulse was 128 (normal 60-90) and irregular and the staff were unable to obtain the resident's blood pressure. The note indicated the resident's family was notified and a message was left.</p> <p>There was a lack of documentation to indicate the resident's physician was notified of the change in level of consciousness, irregular and fast heart beat, and staff unable to obtain the resident's blood pressure.</p> <p>A Progress Note, dated 08/08/13 at 9:45 p.m. indicated the resident's family returned the call and were coming to the facility.</p> <p>A Telephone Physician's Order, dated 08/08/14 at 10 p.m., indicated an order to send the resident to the Emergency Room for an evaluation and treatment.</p> <p>A Progress Note, dated 08/08/14 at 11:45 p.m., indicated, "At 11:45 p.m. (three hours and 45 minutes later) res (resident) sent to (Hospital Name) Emergency Room (ER) via (Name) Ambulance per family request. Resident did not eat dinner and did not respond to staff. BP (blood pressure) 80/60 (normal 90-120/60-90)...P (pulse) 128, R (respirations) 20. Called (Hospital Name)</p>		<p>the deficient practice. How the facility will identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken..All staff will be re-educated, and reminded, of the Change in Condition policy currently in place with an emphasis on notifying the physician, POA, and documentation. LPN involved received corrective action due to her failure to notify the resident's physician upon a change in condition. What measures will be put in place or what systemic changes will the facility make to make sure the alleged deficient practice does not occur. Staff will be in-serviced on the importance of documentation and the crucial role it plays in the care and treatment of residents. Proper documentation is critical to good communication pertaining to a resident's potential change in condition. Shift change meetings will occur and HWD and/or ED will attend to monitor for change in condition. How will the corrective actions be monitored to ensure that the deficient practice will not reoccur, i.e. what quality assurance programs will be put in place. HWD and Executive Director will review the 24 Hour Report Log daily for resident change in condition. Executive</p>				

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	<p>ER to give report..."</p> <p>A Progress Note, dated 08/08/14 (sic) (08/09/14) at 12 a.m., indicated the resident's physician was notified of the resident's condition and an order was received to transfer the resident to the Emergency Room.</p> <p>A Hospital ER note, indicated the resident was initially seen in the ER on 08/09/14 at 12:22 a.m.. The note indicated "...Chief Complaint Per NH (Nursing Home), pt (patient) is 'dehydrated', that she has not eaten in 5 days, and that she is 'less responsive'...History of Present Illness The patient presents with 'heart racing'. The onset was unknown...irregular, skipping beats fast...dry oral mucosa...hgb (hemaglobin) 5.7 (normal 11.7-13.8),... sodium 144 (normal 136-145), potassium 4.2 (normal 3.5-5),... BUN (kidney function) 21 (normal 10-20), Creatinine (kidney function) 1.1 (normal 0.5-1.1)..."</p> <p>The hospital diagnoses included, but were not limited to, anemia, advanced dementia, tachycardia (fast heart beat), and dehydration.</p> <p>During an interview with LPN #6, on 08/20/14 at 1:55 p.m., she indicated if the</p>		<p>Director will conduct weekly audit of charts to ensure that proper notification for all change of conditions have been reported properly. By what date will these systemic changes be put into place. Immediately and on-going; September 8, 2014</p>	

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	<p>resident did not eat or had a change in condition, the resident's physician should be notified. She indicated she had not called the resident's physician due to the resident had end stage dementia and was a do not resuscitate. She indicated the resident was not in distress. LPN #6 indicated further she had not transferred the resident to the hospital because she did not know if the family wanted her transferred. She indicated she wanted to wait until the family came in to call the physician incase the family wanted to ride to the hospital with the resident. She indicated it did not seem like it was an emergency due to the resident did not show signs of pain.</p> <p>During an interview with the Director of Health Services (DHS) on 08/21/14 at 9:33 a.m., she indicated the resident's physician should have been notified when the condition change was assessed at 8 p.m. She indicated they should not have waited for the family to come in to the facility.</p> <p>B. During an interview on 08/20/14 at 1:13 p.m., CNA #1 indicated the Resident #B had not been eating or drinking well for about two weeks. CNA #1 indicated the resident would not take bites of food when the staff attempted to feed her. CNA #1 indicated the resident</p>			

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	<p>would drink water and the Nurses' were aware the resident was not eating well.</p> <p>During an interview on 08/20/14 at 1:16 p.m., CNA #2 indicated Resident #B was not eating well for about three weeks. CNA #2 indicated the resident would consume a few bites of her meal. CNA #2 indicated the resident slept often. CNA #2 indicated the resident would drink fluids but not as much as she used to. CNA #2 indicated the Nurses' were aware the resident was not eating well.</p> <p>During an interview on 08/20/14 at 1:19 p.m., CNA #3 indicated Resident #B did not want to stay awake to eat and the staff would attempt to feed her and the resident would shake her head away. CNA #3 indicated sometimes the resident would take a drink or two and the Nurses' were aware the resident was not eating well. CNA #3 indicated this had happened a few days prior to the resident being transferred to the hospital (08/08/14).</p> <p>During an interview on 08/20/14 at 1:23 p.m., CNA #4 indicated Resident #B was not eating well and sometimes would not eat anything. She indicated the resident would sleep and would keep her head down with her eyes closed. CNA #4 indicated the staff would attempt to feed</p>			

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	<p>her and the resident would turn her head away. She indicated the Nurses' are in the dining room so they are aware the resident was not eating.</p> <p>During an interview on 08/20/14 at 1:27 p.m., LPN #5 indicated she was aware the resident was not eating and drinking well. She indicated the resident would, "take a few bites here and there". She indicated she does not remember letting the resident's physician know about the decrease in appetite.</p> <p>During an interview on 08/20/14 at 1:55 p.m., LPN #6 indicated Resident #B slept often. She indicated sometimes the resident would eat but she did not eat a lot.</p> <p>During an interview on 08/20/14 at 2:10 p.m., CNA #7 indicated Resident #B's eating habits had slowed down. CNA #7 indicated the resident would take a few bites but usually refused her meal. CNA #7 indicated the resident would drink sips of fluid and when the staff made attempts to feed the resident she would shake her head no and would not open her mouth. CNA #7 indicated the resident had declined and had required more help with her ADL's.</p> <p>During an interview on 08/20/14 at 2:14</p>			

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	<p>p.m., CNA #8 indicated Resident #B had not been eating well for awhile. CNA #8 indicated the resident had been declining and the Nurses' were aware the resident was not eating or drinking. CNA #8 indicated sometimes the resident would take sips of fluid. CNA #8 indicated the resident was not able to stand like she used to, was more incontinent and slept a lot more.</p> <p>During an interview on 08/20/14 at 2:18 p.m., CNA #9 indicated sometimes Resident #B would not eat and she would supplement her meal with soup and the resident would consume some of the soup. CNA #9 indicated the resident's food and fluid intake had declined and the resident's ADL ability had declined. CNA #9 indicated the resident would hold her head down and would no longer help stand with transfers. CNA #9 indicated the resident had noticed the decline in the week prior to the resident being transferred to the hospital.</p> <p>During an interview on 08/20/14 at 2:23 p.m. CNA #10 indicated Resident #B was not eating well and the resident had declined in her ADL's. CNA #10 indicated the resident required more help with standing and other ADL's.</p> <p>Review of the Progress Notes, dated</p>						

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	<p>06/17/14 through 08/08/14 lacked documentation to indicate the resident's physician and responsible party had been notified of the decline in food and fluid intake and ADL's.</p> <p>The resident's weights indicated weight of 125 pound on 02/12/14 and 133 pounds on 07/30/14.</p> <p>During an interview on 08/21/14 at 9:33 a.m. with the Director of Health Services (DHS), she indicated she had updated the resident's Responsible Party on 07/14/14 about the resident required increased staff assistance with her care and increased assistance with her meals. The DHS indicated she had not notified the resident's physician because the resident had not lost weight. She indicated she was not aware the resident was not eating and had observed the resident taking bites of food. She indicated the resident had never ate a lot of food and the resident was consuming the health shakes.</p> <p>A facility policy, received as current from the Executive Director, dated 08/01/97, titled, "Change of Condition", indicated, "...Emergent: 1. Residents with unstable or potentially life threatening medical or mental health conditions should be evaluated by a physician or sent to the emergency department, as warranted by</p>			

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	<p>their condition...2. 911 should be called immediately for residents experiencing life-threatening emergencies...3. The physician and legally responsible party will be notified of the resident's change in condition and transported to the hospital...Non-Emergent: 1. The Physician and legally responsible party will be notified of resident's change of condition. 2. All necessary medical care and treatment measures will be initiated and provided at the direction of the physician..."</p> <p>This Residential Tag relates to complaint IN00154736.</p>						