

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 07/11/2013
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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 a State Licensure Survey. This visit also included the Investigation of Complaint IN00129018 and IN00130363.</p> <p>Complaint IN00129018-Substantiated. State residential deficiencies related to the allegations are cited at R036, R051 and R349.</p> <p>Complaint IN00130363-Substantiated. State residential deficiencies related to the allegations are cited at R036 and R217.</p> <p>Survey Dates: July 10 & 11, 2013</p> <p>Facility Number: 010890 Providers Number: 010890 AIM Number: N/A</p> <p>Survey Team: Cynthia Stramel, R.N., T.C. Heather Tuttle, R.N. Caitlyn Doyle, R.N. Lara Richards, R.N. 7/10/13</p> <p>Census Bed Type: Residential: 111 Total: 111</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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	<p>Census Payor Type: Other: 111 Total: 111</p> <p>Sample: 11</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 15, 2013, by Janelyn Kulik, RN.</p>						

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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 ensure the resident's Physician was promptly notified of a significant change in condition related to a weight loss and follow up appointment after resident was seen in the Emergency Room for an urinary tract infection for 2 of 11 sampled residents. (Resident #B and #D)</p> <p>Findings include:</p> <p>1. The record for Resident #D was reviewed on 7/10/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, history of spinal meningitis, frailty, and macular degeneration with vision deficit. The resident was admitted to the facility on 10/19/12.</p> <p>Review of Nurse's Notes dated</p>	R000036	<p>R 036 The community of Brentwood at La Porte requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the communities desire to comply with the regulations and to continue to provide quality care. R 036 1) Immediate actions taken for those residents identified as # B: Resident's son was made aware of the order for a MD follow up in 3 days and Nursing care continued with antibiotic until completed. MD appointment scheduled for revisit, however the Son did not make the appointment, this pertains to a past event and has no bearing on current condition of resident. Residents Doctor has been notified of residents current</p>	07/27/2013			

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	<p>5/11/13 at 7:25 p.m., indicated the resident became dizzy and almost fell. The resident further complained of being nauseous and was sent to the Emergency Room.</p> <p>Upon return to the facility on 5/11/13 at 11:30 p.m., the resident came back with a prescription for Cipro (an antibiotic) 500 milligrams (mg) every 12 hours for three days for an urinary tract infection. Further review of the discharge instructions indicated for the resident to follow up with her primary Physician in three days.</p> <p>Review of Nursing Progress Notes dated 5/12/13 at 2:00 p.m., indicated nursing staff had let the resident's power of attorney know the resident had to follow up with her Physician in three days.</p> <p>Review of the laboratory results dated 3/6/13 indicated the resident had an urinary tract infection with greater than 100,000 Escherichia Coli and was treated with Cipro 250 mg one capsule every 12 hours times 7 days.</p> <p>Further review of Nurse's Notes indicated there was no further documentation regarding Physician notification of the resident having another urinary tract infection.</p>		<p>condition and community will follow-up as instructed by Doctor for any future revisit. PCP for resident and Family is aware of residents current condition and no further orders have been given. 2) How the Community identified other residents: Residents residing in the community that have the potential to be affected will be monitored and family POA and PCP will be notified; Resident charts were audited to ensure that no other appointments were missed. The Wellness Nurse will be scheduling all appointments moving forward and will notify the resident's POA/responsible party. 3) Measures put into place / System changes: Monitoring Process: Brentwood "Assisted Living" will continue to monitor resident weights twice yearly and update the Physician and Family of any change of condition. The RCD and Director of Dining Services will meet and discuss any weight loss issues and obtain appropriate Interventions. Residents residing on the memory care neighborhood will continue to be weighed monthly and will follow the same protocol. Nursing Staff educated physician notification on 7/18/2013. Nursing staff will contact the family in regards to</p>				

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	<p>Interview with LPN #2 on 7/10/13 at 2:20 p.m., indicated it was the resident's family's responsibility to make the follow up appointment to see the Physician.</p> <p>Interview with the Resident Care Director on 7/11/13 at 11:00 a.m., indicated the nurse should have followed up with the family to make the appointment with the Doctor.</p> <p>2. The record for Resident #B was reviewed on 7/11/13 at 8:50 a.m. The resident moved into the facility in May</p>		<p>the follow up appointments and will be responsible for follow up with resident POA's as to date, times, transportation, etc. Nursing staff will follow up with ER/Medical Records to ensure that documentation is obtained to promote accurate and thorough follow up of resident care needs. The Nurse receiving the resident back onto the unit will complete necessary orders. The community will utilize the Observation/Monitoring tool to communicate pertinent resident information to the community team Physician will be notified promptly of resident change in condition. 4) How the corrective action will be monitored: RCD will review the Observation/Monitoring tool daily (5 times a week). A clinical meeting will be held daily (Mon-Fri) to review resident care needs and unsure appropriate follow up completed. These practices will be reviewed for 6 months during the QA meetings and additional measures will be implemented as indicated. 5) Responsible Person RCD/Designee 6) Date of Compliance July 27,2013.</p>				

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	<p>of 2012. Diagnoses included, but were not limited to, osteoarthritis and dementia.</p> <p>Recorded weights were as follows: May 2012- 165.8 pounds November 2012- 161.8 pounds June 2013- 139.0 pounds July 2013- 132.0 pounds</p> <p>The July 2013 Physician Order Statement indicated the resident was on a regular, low salt diet. There was no documentation in the clinical record the resident's Physician was notified of the weight loss. There was no order for nutritional supplements.</p> <p>Interview on 7/11/13 at 11:34 a.m., with the Resident Care Director (RCD), indicated the Physician had not been notified of the resident's weight loss. She further indicated they were to notify the Physician if a resident lost more than 5 percent of their weight in one month. She indicated the Physician should have been notified of the resident's weight loss.</p> <p>This State Residential Rule relates to Complaints IN00129018 and IN00130363.</p>						

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R000051	<p>410 IAC 16.2-5-1.2(u) Residents' Rights - Offense (u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident ' s medical symptoms.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from chemical restraints related to administering as needed Seroquel (an antipsychotic medication) without any interventions or indications tried first prior to administration for 1 of 3 residents reviewed for psychotropic medication use in the sample of 11. (Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 7/10/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, history of spinal meningitis, frailty, and macular degeneration with vision deficit. The resident was admitted to the facility on 10/19/12.</p> <p>Review of Physician Orders dated 10/19/12 indicated Seroquel 25 milligrams (mg) may give one tab in the morning as needed and also one tab for agitation/anxiety.</p>	R000051	<p>R 051</p> <p>The community of Brentwood at La Porte requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the communities desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: Resident "D" PCP has been notified and medication and condition has been reviewed and PRN Seroquel has been discontinued.</p> <p>2) How the Community identified other residents:</p>	07/18/2013			

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	<p>Review of Physician Orders dated 10/19/13 indicated Seroquel 25 mg give one tab daily after dinner.</p> <p>Review of the Medication Administration Record (MAR) for the month of April 2013 indicated the resident received the as needed Seroquel on 4/25/13 at 9:00 a.m. The reason for the administration of Seroquel was for "complaints of anxiety."</p> <p>Review of the 5/13 MAR indicated the resident received the as needed Seroquel on 5/3/13 at 9:00 a.m., for "complaints of agitation." The resident also received the as needed Seroquel on 5/8/13 for "complaints of agitation."</p> <p>Review of Nursing Progress Notes dated 4/25/13 indicated the only documented entries were at 7:20 a.m., 3:00 p.m., and 7:00 p.m., in which they all indicated the resident made no attempts to leave the facility. There was no documentation of the resident's anxiety or any interventions tried first before administering the as needed Seroquel.</p> <p>Review of Nursing Progress Notes dated 5/3/13 and 5/8/13 indicated</p>		<p>Resident orders were reviewed for anti-psychotics.</p> <p>3) Measures put into place / System changes: Nursing staff educated on 7/18/13 that medication requires the appropriate diagnosis. Nursing staff educated to document non-pharmacological interventions prior to administration of a PRN medication. PCP's have been notified of the need for a Medication and Diagnosis review regarding the Anti-Psychotic medications ordered and that each medication must have supporting diagnosis based on resident condition.</p> <p>4) How the corrective actions will be monitored: RCD will complete monthly review of medications to ensure supporting diagnosis for prescribed medications. Results of audits will be reviewed per our daily 24 hour book and clinical meetings and the monthly Quality Assurance meeting x 6 months.</p> <p>5) Responsible Person RCD/Designee</p>				

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	<p>there was no documentation in Nurse's Notes on those days. Further review of Nurse's Notes indicated there was no documentation of any interventions tried first prior to administering the as needed Seroquel. Further review of the Nurse's Notes indicated there was no documentation of the resident's agitation on those days.</p> <p>Interview with LPN #2 on 7/10/13 at 2:10 p.m., indicated there was no behavior monitoring log kept for the resident. She further indicated documentation of the resident's behaviors should be in the Nurse's Notes. The LPN indicated the time, date, and reason were required documentation on the back of the MAR.</p> <p>Interview with the Resident Care Director on 7/11/13 at 2:20 p.m., indicated there was no documentation of any behavior logs for the resident, nor was there any documentation of the resident's behaviors of anxiety or agitation on the above mentioned dates when the resident received the as needed Seroquel. She further indicated the nurse should have documented some kind of interventions of what they did prior to giving the as needed Seroquel.</p>		<p>6) Date of Compliance July 18, 2013</p>				

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	This State Residential Rule relates to Complaint IN00129018.			

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review , the facility failed to ensure a resident's evaluation was reviewed and revised appropriately related to the onset of hallucinations and increased confusion for 1 of 1 residents reviewed for elopement in a sample of 11. (Resident #B).</p>	R000217	<p>R 217</p> <p>The community of Brentwood at La Porte requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute</p>	07/27/2013			

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	<p>Findings include:</p> <p>The record for Resident #B was reviewed on 7/11/13 at 8:50 a.m. Diagnoses included osteoarthritis and dementia. The resident moved into the Assisted Living in May of 2012.</p> <p>Nursing notes dated 1/30/13 at 6:05 a.m., indicated the resident was crying, hallucinating "a man in a truck in her room" [sic], increased confusion was noted.</p> <p>On 2/4/13 the resident received a prescription for Namenda (a dementia medication) during a doctor visit.</p> <p>Nursing notes dated 2/13/13 at 11:30, (no a.m. or p.m.) indicated resident was seeing snakes and worms coming out of her walls. Family had requested Namenda be discontinued.</p> <p>Review of Physician Order dated 3/9/13 indicated to resume Namenda. Further record review indicated the family requested the Namends be discontinued on 3/12/13.</p> <p>Nursing notes dated 3/25/13 at 3:00 a.m., indicated the resident was up at the nurses station with clothes in her</p>		<p>an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the communities desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: This resident currently resides on the Memory Care Neighborhood The Clinical Assessment and Individual Service Plan have been reviewed with the family.</p> <p>2) How the Community identified other residents: Chart review has been completed per the RCD to identify residents with a diagnosis of Dementia or Alzheimer Disease and for documentation of any exit seeking behaviors.</p> <p>3) Measures put into place / System changes: The Nursing Staff has been educated to document change of condition and implementation of interventions appropriate to the changes. This in-service was provided by the RCD. Nursing staff will notify and</p>				

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	<p>hands, crying, and requesting to go home.</p> <p>Nursing notes dated 3/26/13 at 5:00 a.m., indicated the resident had been up three times that night confused and crying.</p> <p>Nursing notes dated 4/18/13 at 5:00 a.m., indicated the resident was crying, seeing bugs in her room and in the hallway. The resident had a suitcase packed.</p> <p>Nursing notes dated 4/23/13 at 6:15 a.m.. indicated the resident was hallucinating bugs in her room, trying to eat her furniture and clothing.</p> <p>Nursing notes dated 5/7/13 at 10:15 p.m., indicated the resident was agitated, carrying around a suitcase and wanting to go home.</p> <p>On 5/16/13 the resident exited the building and walked to a family member's home two blocks away. The family returned her to the facility at 9:10 p.m. She was transferred immediately to the Memory Care unit upon return.</p> <p>Interview with LPN #1 on 7/11/13 at 11:03 a.m. She indicated the resident moved into assisted living in May of</p>		<p>document that the PCP and the POA have been notified of this Change of Condition. The RCD will complete the Change of Condition Assessment. Brentwood Assisted Living will be installing a Wander Guard Door System to the 4 main entries. Tentative date of installation to be determined. 24 hour nursing report book and daily clinical meetings will continue to be monitored.</p> <p>4) How the corrective actions will be monitored:</p> <p>RCD will lead the daily clinical meeting (Mon-Fri) and any Change of Condition will be thoroughly reviewed. Chart audit will be completed weekly with review of 5 records by the RCD. Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months.</p> <p>5) Responsible Person</p> <p>RCD/Designee</p> <p>6) Date of Compliance</p> <p>July 27, 2013</p>				

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	<p>2012. At that time the resident was able to drive a car. She became increasingly confused. She would forget to use her walker and would fall. The LPN indicated, "she would yell out the window for help".</p> <p>Interview with Resident Care Director (RCD) on 7/11/13 at 11:34 a.m., indicated the resident had been diagnosed with mild dementia approximately one month prior to her elopement. Further interview with the RCD indicated the resident probably should have been moved to the Memory Care Unit upon her dementia diagnoses.</p> <p>This State Residential Rule relates to Complaint IN00130363.</p>						

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R000241	<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 observation, record review, and interview, the facility failed to ensure Physician Orders were followed related to obtaining a blood pressure prior to administering an antihypertensive medication for 1 of 5 residents reviewed during medication pass. (Resident #11)</p> <p>Findings include:</p> <p>On 7/11/13 at 8:00 a.m., LPN #1 was observed preparing medications for Resident #11. At that time, the LPN poured Coreg (carvedilol) 37.5 milligrams (mg) 1 1/2 tabs into a medication cup. The LPN then administered the medication to the resident without obtaining her blood pressure.</p> <p>Interview with LPN #1 at that time, indicated the midnight nurse had obtained her blood pressure at 5:00 a.m. The LPN indicated the resident's blood pressure at 5:00 a.m. was 160/82.</p>	R000241	<p>R 241 The community of Brentwood at La Porte requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the communities desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for those residents identified: Nurse was educated per the RCD on the order to monitor Blood Pressure prior to medication and to document accordingly Resident Identified as #11 was assessed with no negative out come noted. 2) How the Community identified other residents: Residents residing in the community that have the potential to be affected as identified by a MAR audit that was completed by the RCD to ensure that vital signs were taken and recorded as ordered.</p> <p>3) Measures put into place / System changes: Nursing Staff in serviced on July 18, 2013 on</p>	07/27/2013			

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	<p>The record for Resident #11 was reviewed at 9:15 a.m. Review of Physician Orders dated 6/10/13 indicated Coreg 37.5 mg. every a.m. Hold if Systolic Blood Pressure (SBP) less than 110 and heart rate less than 55.</p> <p>Further review of Physician Orders dated 6/10/13 indicated Clonidine .2 mg one tablet three times a day every eight hours scheduled for 5:00 a.m., 1:00 p.m., and 9:00 p.m. Hold if SBP less than 110.</p> <p>Interview with RN #1 on 7/11/13 at 9:20 a.m., indicated she gave the resident the Clonidine at 5:00 a.m. and took her blood pressure prior to administration.</p> <p>Interview with LPN #1 on 7/11/13 at 9:30 a.m., indicated she did not take the resident's blood pressure as well as her pulse prior to administering the Coreg. She further indicated she was unaware the resident's pulse had to be taken prior to administering the Coreg.</p>		<p>standards of practice and of following MD orders. Documentation in-service provided per RCD which included MAR review to assure documentation complete.</p> <p>4) How the corrective actions will be monitored: Nurses will complete shift to shift MAR review to ensure accurate and complete. RCD will complete weekly MAR audit ED to complete monthly MAR audit. Results of monitoring will be reviewed in the monthly Quality Assurance meeting x 6 months. 5) Responsible Person RCD/Designee 6) Date of Compliance July 27, 2013</p>				

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R000297	<p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.</p> <p>Based on observation, record review, and interview, the facility failed to ensure multi-dose vials of insulin were not used passed the manufactures insulin storage recommendations for 1 of 8 multi-dose vials of insulin observed. (Resident #11)</p> <p>Findings include:</p> <p>On 7/11/13 at 8:00 a.m., LPN #1 was preparing to administer Humalog Insulin to Resident #11. At that time, she removed a multi-dose vial of insulin from the box. The "date opened" sticker on the outside of the box indicated 6/10/13. The label on the box indicated to discard any unused portion 28 days after opening. The LPN then drew up two units of insulin and administered it to Resident #11.</p> <p>Interview with LPN #1 at the time, indicated the resident received Humalog Insulin per a sliding scale and based on her blood sugar. The</p>	R000297	<p>R 297 The community of Brentwood at La Porte requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the communities desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for those residents identified: Out of date insulin was destroyed. Pharmacy contacted clarified time of new insulin delivery. 2) How the Community identified other residents: Residents receiving insulin have the potential to be affected. An audit was completed by the RCD of the Medication room and medication carts to verify dates on other Insulin's and other medications as indicated. No other outdated medications were noted.3) Measures put into place / System changes: Nursing staff educated to observe open date marked on vials and to reorder insulin 5 days before</p>	07/18/2013			

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	<p>LPN further indicated she was unaware of how long Humalog Insulin could be stored after being opened.</p> <p>Review of the current 10/6/11 Insulin Storage Recommendations provided by the Resident Care Director, indicated Humalog Insulin could be stored for 28 days after opening, then the rest should be discarded.</p> <p>Interview with the Resident Care Director on 7/11/13 at 11:00 a.m., indicated the unused portion of the Humalog Insulin should have been discarded 28 days after opening.</p>		<p>expiration. Insulin Storage Poster in place in medication room. RCD to complete weekly MAR audit, which includes med room review and med refrigerator. 4) How the corrective actions will be monitored: Weekly MAR audit which includes med review and med room refrigerator per RCD Monthly med room audit per ED Results of will be reviewed in the monthly Quality Assurance meeting x 6 months. 5) Responsible Person RCD or Designee 6) Date of Compliance July 18, 2013</p>				

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R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure each resident's clinical record was complete and accurate related to an indication for the use of Seroquel (an antipsychotic medication) for 2 of 3 resident's reviewed for psychotropic medication. (Resident #C and #D)</p> <p>Findings include:</p> <p>1. The record for Resident #C was reviewed on 7/10/13 at 1:50 p.m. The resident's diagnoses included, but were limited to, bladder cancer and Alzheimer's disease. The resident was admitted to the facility on 1/24/13.</p> <p>Review of Physician Orders dated 5/28/13 indicated Seroquel 25 milligrams (mg) 1/2 tab 12.5 mg every morning and Seroquel 25 mg one tab every night.</p>	R000349	<p>R 349</p> <p>The community of Brentwood at La Porte requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the communities desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: Residents Identified, PCP was immediately notified with the request for a medication and diagnosis</p>	07/18/2013			

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	<p>Further record review indicated there was no documented behaviors of Schizophrenia, acute manic episodes associated with bipolar disorder, and depression associated with bipolar disorder.</p> <p>Interview with the Resident Care Director on 7/11/13 at 2:20 p.m., indicated there was no indication for the use of the Seroquel.</p> <p>2. The record for Resident #D was reviewed on 7/10/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, history of spinal meningitis, frailty, and macular degeneration with vision deficit. The resident was admitted to the facility on 10/19/12.</p> <p>Review of Physician Orders dated 10/19/12 indicated Seroquel 25 milligrams (mg) may give one tab in the morning as needed and also one tab for agitation/anxiety.</p> <p>Review of Physician Orders dated 10/19/13 indicated Seroquel 25 mg give one tab daily after dinner.</p> <p>Further record review indicated there was no documented behaviors of Schizophrenia, acute manic episodes</p>		<p>review. Physician reviewed meds and diagnosis for Seroquel use.</p> <p>2) How the Community identified other residents: Residents POS were reviewed for anti-psychotics and PCP's were notified of requirements supporting diagnosis.</p> <p>3) Measures put into place / System changes: Records will be reviewed for supporting documentation of diagnosis of accurately documented. Staff educated and understands every medication requires the appropriate diagnosis. Nursing staff educated in daily clinical meetings. Staff educated to chart all interventions prior to administration of a PRN anti-anxiety medication and the results. PCP have been notified of the need for a Medication and Diagnosis review regarding the Anti-Psychotic medications ordered.</p> <p>4) How the corrective actions will be monitored:</p>				

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	<p>associated with bipolar disorder, and depression associated with bipolar disorder (all clinical reasons for the use of Seroquel).</p> <p>Interview with the Resident Care Director on 7/11/13 at 2:20 p.m., indicated there was no indication for the use of the Seroquel.</p> <p>This State Residential Rule relates to Complaint IN00129018.</p>		<p>Daily Clinical meetings and the monthly Quality Assurance meeting x 6 months. Residents receiving Psychotropic medications will be monitored monthly for effectiveness and medication compliance.</p> <p>5) Responsible Person RCD/Designee</p> <p>6) Date of Compliance July 18, 2013</p>		

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R000407	<p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control was maintained related to cleaning the glucometer (a device used to take a resident's blood sugar) after use for 1 of 1 glucometer's observed. (Resident #11)</p> <p>Findings include:</p> <p>On 7/11/13 at 8:00 a.m., LPN #1 was observed preparing to do a glucometer for Resident #11. At that time, the LPN removed the machine from the canvas zipper pouch that had the resident's room number on it, placed clean gloves on her hands, and used the lancet to prick the resident's finger. The LPN did not clean the machine prior to obtaining the blood sugar. After she obtained</p>	R000407	<p>R 407 The community of Brentwood at La Porte requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the communities desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for those residents identified: Nursing staff educated for appropriate cleaning procedure of Glucometers 2) How the Community identified other residents: The residents with glucometers have the potential to be effected. 3) Measures put into place / System changes: Nursing staff educated on glucometer cleaning procedure. Timers obtained for each medication room to monitor time</p>	07/27/2013

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	<p>the blood sugar, the LPN then removed her gloves, and placed the lancet and strip into the sharp's container. The LPN then placed the glucometer machine back into the zipper canvas pouch without immediately cleaning the machine.</p> <p>Interview with LPN #1 on 7/11/13 at 8:30 a.m., indicated each resident has their own glucometer machine. She further indicated the midnight shift nurse usually cleans the resident's glucometers. The LPN indicated she routinely does not clean a glucometer immediately after she uses it.</p> <p>Review of the current 12/17/02 Glucometer Cleaning policy indicated "The following recommendations should be followed regarding the cleaning and disinfection of glucometers after each resident use: The exterior surfaces should then be cleaned following the manufacture's directions or by using a cloth/wipe that contains a dilute bleach solution of 1:10."</p> <p>Interview with the Resident Care Director on 7/11/13 at 11:00 a.m., indicated the glucometer machine should be cleaned after each resident use.</p>		<p>duration of air dry. 4) How the corrective actions will be monitored: RCD will randomly observe cleaning of glucometers by nursing staff and will give added education or counseling as indicated. Findings of random audits will be reviewed at Quality Assurance meeting x 6 months.</p> <p>5) Responsible Person RCD/Designee 6) Date of Compliance July 27, 2013</p>				

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