

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 02/25/2014
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NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: February 24 & 25, 2014</p> <p>Facility number: 002627 Provider number: 002627 AIM number: NA</p> <p>Survey team: Lara Richards, RN-TC Heather Tuttle, RN Yolanda Love, RN</p> <p>Census bed type: Residential: 101 Total: 101</p> <p>Census payor type: Other: 101 Total: 101</p> <p>Sample: 8</p> <p>These State residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 27, 2014, by Janelyn Kulik, RN.</p>	R000000	<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.</p> <p>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>	
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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 ensure the Physician was notified of a change in a resident's urinary output following the insertion of a foley catheter for 1 of 7 records reviewed. (Resident #4)</p> <p>Findings include:</p> <p>The record for Resident #4 was reviewed on 2/25/2014 at 10:25 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and urinary incontinence.</p> <p>An entry in the Nursing Progress notes dated 11/15/2013 at 2:30 p.m., indicated the hospice nurse</p>	R000036	<p>R 036 Residents' Rights- Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Resident #4 passed away on 2/27/14 from end stage COPD and MS How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? Chart audits will be completed for those residents who have had a change of condition within the last 30 days for physician notification of these changes .and follow up will be completed as necessary.</p> <p>What measures will be put in place or what systemic changes will the facility make to ensure the</p>	03/04/2014
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	<p>visited the resident and a foley catheter was inserted.</p> <p>Documentation in the Nursing Progress notes dated 11/16/2013 at 4:00 p.m., indicated the resident's urine was dark and thick and golden amber in color.</p> <p>An entry in the Nursing Progress notes dated 11/17/2013 at 6:00 a.m., indicated the resident's foley catheter was patent and her urine was dark amber in color. At 3:00 p.m., documentation indicated the resident's output was dark. At 6:00 p.m., documentation indicated the resident's urine remained dark and thick. Fluids were encouraged.</p> <p>Documentation in the Nursing Progress notes dated 11/18/2013 at 5:50 a.m., indicated the resident's urine was dark. At 8:00 p.m., the resident's urine remained thick and dark.</p> <p>An entry in the Nursing Progress notes dated 11/19/2013 at 3:15 a.m., indicated the resident's foley catheter was patent and was draining a dark thick small amount of urine.</p> <p>There was no documentation to</p>		<p>alleged deficient practice does not recur? · Nurses and QMA's have been re-educated on 3/4/14 on the requirement that physician's be notified for a resident change in condition. · RCD or designee will audit medical records daily of any resident that is reported to have a change of condition for 30 days and then weekly for 60 days to monitor compliance.. 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?</p> <p>· The community CQI committee will complete 5 random chart audits monthly for six months for physician notification of resident change of condition and follow up as is necessary. By what date will these systemic changes be implemented? · Implemented 3/4/14</p>				

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R000273	<p>indicate the resident's Physician had been notified of the dark urine.</p> <p>Interview with the Resident Care Director on 2/25/2014 at 2:15 p.m., indicated the resident's Physician should have been notified of the change in her urine.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure all kitchen areas were clean and in a state of good repair related to dirty food carts, dirty floors, dusty air vents, and rust stained tiles for 2 of 2 kitchen areas. (The Main Kitchen and the Memory Care Unit Servery). The facility also failed to ensure safe food handling standards were maintained related to serving deserts uncovered on a food serving cart for 2 of 3 dining rooms. (The Main Dining Room and the West Unit Dining Room).</p> <p>Findings include:</p> <p>1. During the Kitchen Sanitation Tour on 2/24/2014 at 2:30 p.m., with</p>	R000273	<p>R- 273 Food and Nutritional Services- Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · No residents were noted to be effected by the alleged deficient practices How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · All residents have the potential to be effected · The Dining Services Director or designee will complete 10 minute sanitation rounds daily for 30 days to monitor compliance and then weekly thereafter. · Dietary associates will be re-educated on foodservice sanitation and serving techniques</p>	03/11/2014

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	<p>the Dietary Service Director, the following was observed:</p> <p>a. Dried food and dried beverage spillage were observed throughout the entire Main Kitchen's food preparation area. Interview with the Dietary Service Director at the time, indicated the floors were mopped once every shift.</p> <p>b. Two black food serving carts located along the wall by the entrance door to the Main Kitchen, had an accumulation of dried food and beverage spillage. Interview with the Dietary Service Director at the time, indicated the food serving carts were to be cleaned after every meal.</p> <p>c. The air vent in the Memory Care Unit Servery was dust filled.</p> <p>d. The tile located beneath the air conditioning unit in the Memory Care Unit Servery was rust stained.</p> <p>Interview with the Dietary Service Director at the time, indicated all of the above areas were in need of cleaning.</p> <p>2. During the follow-up Kitchen Sanitation Tour on 2/25/2014 at</p>		<p>on 3/7/14 and 3/10/14 What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · Items labeled a,b,c and d from the initial kitchen sanitation tour on 2/24/14 in the statement of deficiencies were corrected immediately on 2/24/14. Items labeled a and b on the follow up sanitation tour on 2/25/14 have been corrected as of 3/4/14. The Dining Services Director or designee will complete 10 minute sanitation audits daily for 30 days and then weekly thereafter to monitor compliance · Food will be covered on carts as it is getting served. Staff have been retrained on this requirement. The Executive Director/ designee will attend at least one meal daily for 2 weeks to monitor compliance · 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? · Weekly sanitation audits will be presented to the CQA committee monthly for 6 months to monitor compliance. By what date will these systemic changes be implemented? · Implemented 3/11/14</p>				

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	<p>12:00 p.m., the following was observed:</p> <p>a. Food Server #2 was observed placing ice cream and cake onto her food serving cart and wheeling it into the West Dining Room. The deserts were uncovered and were served from the cart at waist level.</p> <p>b. Food Server #1 was observed placing ice cream and cake onto her food serving cart and wheeling it into the Main Dining Room. The deserts were uncovered and were served from the cart at waist level.</p> <p>Interview with the Dietary Service Director on 2/25/2014 at 12:35 p.m., indicated anytime food is transported it should be covered. He also indicated food servers should not wheel their carts through the dining rooms and serve uncovered food from the carts at waist level.</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. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to lack of documentation of upper respiratory symptoms for a resident receiving an antibiotic and lack of documentation to support the use of an anti-psychotic medication for 2 of 7 records reviewed. (Residents #1 and #4)</p> <p>Findings include:</p> <p>1. The record for Resident #4 was reviewed on 2/25/2014 at 10:25 a.m. The resident's diagnoses included, but were not limited to, bronchitis and chronic obstructive pulmonary disease.</p> <p>A Physician's order dated 2/13/2014, indicated the resident was to receive Clindamycin (an antibiotic) 300</p>	R000349	R 349 Clinical Records-noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?o Resident #4 and Resident #1 had no adverse reactions related to the alleged deficient practices How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · The Resident Care Director and or designee will complete audits on medical records for residents who have an order for antipsychotic medication to adequate diagnosis for said medication· The Resident Care Director and or designee will complete an audit of the infection control log weekly to identify residents receiving ABT therapy and audit medical records for those on ABT weekly to ensure proper assessment of resident adverse reactions are completed and physicians notified if	03/04/2014			

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	<p>milligrams by mouth twice a day for 20 days related to an upper respiratory infection.</p> <p>Entries in the Nursing Progress notes dated 2/14/2014 at 2:48 a.m., 3:30 p.m., and 11:10 p.m., indicated the resident had no adverse reactions to the antibiotic. There was no documentation related to the resident's lung sounds.</p> <p>Documentation in the Nursing Progress notes dated 2/15/2014 at 3:00 a.m., 2:50 p.m., 5:00 p.m., and 8:00 p.m., again indicated the resident had no adverse reactions to the antibiotic. There was no documentation related to the resident's lung sounds.</p> <p>Entries in the Nursing Progress notes dated 2/16/2014 at 6:00 a.m., 3:00 p.m., and 8:30 p.m., indicated the resident had no adverse reactions to the antibiotic. There was no documentation related to the resident's lung sounds.</p> <p>Interview with the Resident Care Director on 2/25/2014 at 2:15 p.m., indicated when a resident was receiving an antibiotic, documentation should be completed for the duration the antibiotic was</p>		<p>indicated.. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · Licensed nurses and qualified medication assistants were re-educated 3/4/14 on documenting assessments for signs and symptoms of adverse reactions when residents are on ABT therapy and reviewing for proper diagnosis to be used for anti-psychotic medication orders · The Resident Care Director and or designee will complete audits weekly for any resident medical records who have received new orders for antipsychotic medications and / or ABT therapy for 6 months to monitor compliance and on a random basis thereafter. 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? · The Resident Care Director and or designee will complete audits weekly for 6 months and on a random basis thereafter for any resident medical records who have received new orders for antipsychotic medications and / or ABT therapy. · Weekly audit findings will be presented to the CQI committee monthly for 6 months to monitor compliance By what date will these systemic changes be implemented? Implemented by</p>				

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	<p>received. She also indicated adverse reactions as well as what symptom the antibiotic was being used to treat should be documented as well.</p> <p>2. The record for Resident #1 was reviewed on 2/25/2014, at 10:40 a.m. The resident was admitted to the facility on 7/6/2012. The resident's diagnoses included, but were not limited to, high blood pressure, gout, neurogenic bladder, hyperkalemia, deep vein thrombosis, neuropathy, osteoarthritis, and irritable bowel syndrome.</p> <p>Review of a Physician Fax dated 2/17/2014, at 8:48 p.m., indicated "Spouse concerned over lack of sleep. Says resident is up all night. Requesting MD (Physician) to be faxed in regards to request some sort of sleep aid for the resident."</p> <p>Review of Nursing Progress Notes dated 2/18/2014, (no time) indicated "This nurse called (Physician name) regarding need something to sleep at night. Per Dr. will call tomorrow as he was not in the office today. (sic)</p> <p>Continued review of Nursing</p>		3/4				

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	<p>Progress Notes dated 2/19/2014, at 10:00 a.m.," Per Dr. (name); Seroquel (an antipsychotic medication) ordered every night for resident...."</p> <p>Review of Physician Orders dated 2/19/2014, indicated Seroquel 25 milligrams at night.</p> <p>Review of the 2/2014 Medication Administration Record, indicated the resident received the Seroquel 2/19-2/24/2014.</p> <p>Interview with LPN #1 on 2/25/2014, at 11:50 a.m., indicated the Physician had ordered the Seroquel for sleep because she was not sleeping at night. The LPN indicated the resident did have mild confusion but she did not have any diagnoses to support the use of the antipsychotic medication.</p>			