STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE GRANGER	430 CLEVELAND RD, GRANGER, , 46530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00360228 and IN00361620. Complaint IN00360228 - Substantiated. State deficiencies related to the allegations are cited at R0089. Complaint IN00361620 - Substantiated. State deficiencies related to the allegations are cited at R0089 and R0241. Survey date: September 1, 2021 Facility number: 002656 Residential Census: 16 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed on September 9, 2021.	R 0000		
R 0089	Administration and Management -	R 0089		10/01/2021

	Noncompliance 410 IAC 16.2-5-1.3(e)(1-2)(f) (e) An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1): (1) health facility; or (2) hospital-based long-term care unit; at a time. (f) In the administrator's absence, an individual shall be authorized, in writing, to act on the administrator's behalf. Based on observation and interview, the facility failed to employ an administrator for the facility and there was no individual authorized in writing to act on an administrators behalf. This had the potential to affect all 16 resident's who resided at the facility. Findings include: On 9/1/21 at 9:40 A.M., upon entrance into the facility, several staff members were observed seated in chairs around the lobby area. The staff indicated they were having their usual morning meeting. None of the staff members wore a name tag to indicate they were the Administrator. The Business		R 089 410 IAC 16.2-5-1.3(e)(1-2)(f) Administration and Management - Noncompliance (e) An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1): (1) health facility; or (2) hospital-based long-term care unit; at a time. (f) In the administrator's absence, an individual	

	Office Manager indicated the facility did not currently have an Administrator nor a Health and Wellness Director (nurse) but that one had been hired and she was out of the facility for orientation. She was not sure who was covering for administrative concerns. 9/1/21 at 10:01 A.M., during an entrance conference meeting, attended by the Business Office Manager and day shift QMA (Qualified Medication Aide), both indicated the facility had been without an administrator since mid-July when the previous one had abruptly left without notice. The QMA indicated the Health and Wellness Director (HWD) at their sister facility, was notified for nursing concerns and reportable events that required notification to the Indiana State Department of Health. She indicated the HWD from the sister facility was on her way to this facility and would arrive shortly. 9/1/21 at 10:20 A.M., the Business Office Manager indicated she had just gotten off the phone with the Administrator of another sister facility, located in central Indiana, who indicated they were not responsible for this particular facility as their license was attached to their facility in central Indiana but they would be willing to assist		shall be authorized, in writing, to act on the administrator's behalf. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The District Director of Operations will be responsible for designating another Brookdale sister community Executive Director as interim administrator, and notifying the ISDH accordingly with the name of that person. Once a new hire is made, the ISDH will be notified with that change. -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	

	the Business Office Manager with any concerns. 9/1/21 at 10:33 A.M., the Health and Wellness Director from the sister facility arrived and indicated she provided oversight services to the nursing staff but was not an Administrator licensed to be in charge of the facility. This State Residential finding relates to Complaints IN00360228 and IN00361620. Based on observation and interview, the facility failed to employ an administrator for the facility and there was no individual authorized in writing to act on an administrators behalf. This had the potential to affect all 16 resident's who resided at the facility. Findings include: On 9/1/21 at 9:40 A.M., upon entrance into the facility, several staff members were observed seated in chairs around the lobby area. The staff indicated they were having their usual morning meeting. None of the staff members wore a name tag to indicate they were the Administrator. The Business Office Manager indicated the facility did not currently have an Administrator nor a Health and Wellness Director (nurse) but that one had been hired and she was out of the facility for		All residents have the potential to be affected by alleged deficient practice, therefore the Interim Administrator will be responsible for day to day management of the community, under the direct supervision of the District Director of Operations. -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Community will work to hire new licensed health care administrator for community. Going forward in the absence of an administrator individual will be authorized, in writing to act on the administrator’s behalf -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and While vacancy in	

	orientation. She was not sure who was covering for administrative concerns. 9/1/21 at 10:01 A.M., during an entrance conference meeting, attended by the Business Office Manager and day shift QMA (Qualified Medication Aide), both indicated the facility had been without an administrator since mid-July when the previous one had abruptly left without notice. The QMA indicated the Health and Wellness Director (HWD) at their sister facility, was notified for nursing concerns and reportable events that required notification to the Indiana State Department of Health. She indicated the HWD from the sister facility was on her way to this facility and would arrive shortly. 9/1/21 at 10:20 A.M., the Business Office Manager indicated she had just gotten off the phone with the Administrator of another sister facility, located in central Indiana, who indicated they were not responsible for this particular facility as their license was attached to their facility in central Indiana but they would be willing to assist the Business Office Manager with any concerns. 9/1/21 at 10:33 A.M., the Health and Wellness Director from the sister facility arrived and		administrator exists, District Director of Operations and/ or designee to check on weekly basis to ensure that covering administrator is listed in writing for community. -By what date the systemic changes will be completed. 10.1.21	

	indicated she provided oversight services to the nursing staff but was not an Administrator licensed to be in charge of the facility. This State Residential finding relates to Complaints IN00360228 and IN00361620.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (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. Based on interview and record review, the facility failed to provide medications per physician orders for 1 of 1 residents reviewed for medication administration which resulted in the resident's transfer to inpatient care due to unmanaged symptoms of restlessness and agitation (Resident K). Findings include: On 9/1/21 at 12:15 P.M., the closed record for Resident K	R 0241	R 241 410 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	10/01/2021

	was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and heart failure. The resident was receiving hospice services. On 9/1/21 at 1:38 P.M., Resident K's family member was interviewed. She indicated the following event had occurred in the early morning hours of 7/9/21. She had received a call around 3:30 a.m. from a staff member who indicated Resident K was extremely agitated, restless, and kept removing her oxygen. The family member arrived to the facility and was let in by 3 CNA's (Certified Nurse Aide) who directed her to the resident's room. The resident was very restless and agitated and kept removing the oxygen tubing from her nose. The family member asked if the resident could have medication to relax her as the resident had an order for medication to be given when needed for pain and restlessness. The 3 CNA's indicated they could not administer medications and there was no nurse or QMA (Qualified Medication Aide) working in the facility that night. The family member asked who could give her medications and the CNA's said "not us". One of the CNA's called hospice who indicated they would send someone as soon as they could but the hospice nurse was an		administered by licensed nursing personnel or qualified medication aides. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident no longer resides at community, she was transferred to inpatient hospice facility on 7/9/21. -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Alleged deficient practice has the potential to affect all residents receiving medication management. An audit of PRN medications was performed by nurse designee to determine if	

	hour away and tending to another patient. The resident was in pain, restless, and agitated until 6:30 a.m. when an agency nurse showed up to work the day shift and administered the resident medication for pain and restlessness which was effective in helping the resident to relax. The family member indicated she'd felt angry and helpless because there was nothing she could do to comfort the resident and there was no one available to administer her medications. The resident had to be transported to another facility for inpatient treatment and control of her symptoms and had passed away on 7/12/21. A Personal Service Plan, last updated on 1/18/21, indicated staff were to provide and administer the resident's medications which included, but not limited to, as needed Morphine (strong pain medication). The resident received hospice services who provided her medications and chronic condition management. A Hospice Communication Note, dated 7/6/21 at 8:25 a.m., indicated the resident continued to decline and presented with increased confusion, anxiety, and abnormal rapid breathing. New orders had been initiated, on 7/1/21, to increase her pain		routine scheduled orders could be obtained and would be more appropriate to provide around the clock relief of symptoms to avoid situations such as this in the future. Nurses and Care givers were re-educated on the notification process for communicating with the On-call nurse in order to avoid delays -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; A new Health and Wellness Director, who is a nurse, was hired on Aug. 30th, 2021. During times when community is unable to cover nursing shifts due to staffing shortages community will attempt to utilize emergency staffing plan including assigning sister community nursing associates to cover shift and administer medications or utilizing contract labor to cover shift and administer medications. Should the emergency staffing plan fail to provide needed associate to administer medications the	

	medication from 3 times per day to 4 times a day and increase her anti-anxiety medication-Lorazepam-from 0.5 mg (milligram) routine at bedtime to Lorazepam 0.5 mg routine 3 times daily. The resident continued with restless and agitation and her medications were changed on 7/7/21 and again, on 7/8/21. A Physician order, dated 7/8/21 at 1:30 p.m. was for: 1). Morphine 20 mg/ml (milliliter) 5 mg (0.25 ml) by mouth or sublingual (below the tongue) every 3 hours as needed for pain or shortness of breath. 2). Morphine 20 mg/ml, 5 mg (0.25 ml) by mouth or sublingual every 15 minutes up to 3 doses for crisis dosing-severe pain or shortness of breath. 3). Lorazepam 2 mg/ml-1 mg (0.5 ml) by mouth or sublingual every 6 hours routine and every 3 hours as needed for management of anxiety and restlessness. A MAR (Medication Administration Record) for July 2021, indicated Lorazepam concentrate 2 mg/ml-give 0.5 ml sublingually was to be administered every 6 hours for anxiety and restlessness. The medication was scheduled to be administered at 12 a.m., 6 a.m.,		Health and Wellness Director or designee will be appointed to come in and administer medications as needed. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Executive Director from sister community to monitor schedule for shift openings 5 times per week for 4 weeks; once weekly for 4 weeks; then monthly x4 months In order to ensure proper scheduling and medication administration coverage at the community. -By what date the systemic changes will be completed. 10.1.21	

12 p.m., and 6 p.m. The MAR was blank for administration of the medication on 7/9/21 at 12 a.m. and 6 a.m.

A Hospice Communication Note, dated 7/9/21 at 3:50 a.m., indicated a staff member had contacted hospice and asked for a nurse to come out to the facility because Resident K was restless. The staff member had called the Administrator who had directed them to call the hospice nurse to come and administer the resident's medication as the facility had no nurse on duty to administer them. The on-call hospice nurse was notified.

-At 4:50 a.m., the facility was contacted and hospice staff spoke with CNA 7 (Certified Nurse Assistant) and informed her that the on-call hospice nurse was still on another visit and could be another hour before the nurse could get to the facility. CNA 7 was asked if there was a QMA or nurse that was on-call for the facility and the CNA had replied that there wasn't. CNA 7 indicated that she had called the Administrator, again, and was told there was no nurse or QMA available to administer medications until 6-6:30 a.m.

A handwritten Nurse Note, dated 7/9/21 at 6:30 a.m., indicated the resident had been

medicated for discomfort and anxiety as ordered. The resident's family member was present and had indicated the resident had been restless all night.

A Hospice Communication Note, dated 7/9/21 at 6:32 p.m., indicated the resident was to be transported to inpatient hospice services on this date for "unmanaged symptoms of restlessness and agitation".

On 9/1/21 at 2:31 P.M., the Health and Wellness Director from the sister facility was interviewed. She indicated there had not been a nurse or QMA working from 7/8 at 10:00 p.m. through 7/9/21 at 6:00 a.m. but that there should have been and the resident should've been administered her medications as ordered.

On 9/1/21 at 2:48 P.M., CNA 3 was interviewed. During the interview, she indicated she had been present and working the early morning hours of 7/9/21 and had been caring for Resident K. Resident K had been very restless and agitated and she nor the other CNA's had known what to do. They had called the Administrator who said to call hospice which the CNA's had done but the hospice nurse couldn't come right away and there was no one to administer medications.

She indicated the CNA's had tried to call their sister facility to see if a nurse or QMA could come over and administer the medication but their phone calls hadn't been answered so they called the resident's family to see if she could come to the facility and help the resident relax. There had been no nurse or QMA present and working until 6:30 a.m.

This State Residential finding relates to Complaint IN00361620.

Based on interview and record review, the facility failed to provide medications per physician orders for 1 of 1 residents reviewed for medication administration which resulted in the resident's transfer to inpatient care due to unmanaged symptoms of restlessness and agitation (Resident K).

Findings include:

On 9/1/21 at 12:15 P.M., the closed record for Resident K was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and heart failure. The resident was receiving hospice services.

On 9/1/21 at 1:38 P.M., Resident K's family member was interviewed. She indicated the following event had occurred

in the early morning hours of 7/9/21. She had received a call around 3:30 a.m. from a staff member who indicated Resident K was extremely agitated, restless, and kept removing her oxygen. The family member arrived to the facility and was let in by 3 CNA's (Certified Nurse Aide) who directed her to the resident's room. The resident was very restless and agitated and kept removing the oxygen tubing from her nose. The family member asked if the resident could have medication to relax her as the resident had an order for medication to be given when needed for pain and restlessness. The 3 CNA's indicated they could not administer medications and there was no nurse or QMA (Qualified Medication Aide) working in the facility that night. The family member asked who could give her medications and the CNA's said "not us". One of the CNA's called hospice who indicated they would send someone as soon as they could but the hospice nurse was an hour away and tending to another patient. The resident was in pain, restless, and agitated until 6:30 a.m. when an agency nurse showed up to work the day shift and administered the resident medication for pain and restlessness which was effective in helping the resident to relax. The family member

indicated she'd felt angry and helpless because there was nothing she could do to comfort the resident and there was no one available to administer her medications. The resident had to be transported to another facility for inpatient treatment and control of her symptoms and had passed away on 7/12/21.

A Personal Service Plan, last updated on 1/18/21, indicated staff were to provide and administer the resident's medications which included, but not limited to, as needed Morphine (strong pain medication). The resident received hospice services who provided her medications and chronic condition management.

A Hospice Communication Note, dated 7/6/21 at 8:25 a.m., indicated the resident continued to decline and presented with increased confusion, anxiety, and abnormal rapid breathing. New orders had been initiated, on 7/1/21, to increase her pain medication from 3 times per day to 4 times a day and increase her anti-anxiety medication-Lorazepam-from 0.5 mg (milligram) routine at bedtime to Lorazepam 0.5 mg routine 3 times daily.

The resident continued with restless and agitation and her medications were changed on

7/7/21 and again, on 7/8/21.

A Physician order, dated 7/8/21 at 1:30 p.m. was for:

1). Morphine 20 mg/ml (milliliter) 5 mg (0.25 ml) by mouth or sublingual (below the tongue) every 3 hours as needed for pain or shortness of breath.

2). Morphine 20 mg/ml, 5 mg (0.25 ml) by mouth or sublingual every 15 minutes up to 3 doses for crisis dosing-severe pain or shortness of breath.

3). Lorazepam 2 mg/ml-1 mg (0.5 ml) by mouth or sublingual every 6 hours routine and every 3 hours as needed for management of anxiety and restlessness.

A MAR (Medication Administration Record) for July 2021, indicated Lorazepam concentrate 2 mg/ml-give 0.5 ml sublingually was to be administered every 6 hours for anxiety and restlessness. The medication was scheduled to be administered at 12 a.m., 6 a.m., 12 p.m., and 6 p.m. The MAR was blank for administration of the medication on 7/9/21 at 12 a.m. and 6 a.m.

A Hospice Communication Note, dated 7/9/21 at 3:50 a.m., indicated a staff member had contacted hospice and asked for a nurse to come out to the facility because Resident K was

restless. The staff member had called the Administrator who had directed them to call the hospice nurse to come and administer the resident's medication as the facility had no nurse on duty to administer them. The on-call hospice nurse was notified.

-At 4:50 a.m., the facility was contacted and hospice staff spoke with CNA 7 (Certified Nurse Assistant) and informed her that the on-call hospice nurse was still on another visit and could be another hour before the nurse could get to the facility. CNA 7 was asked if there was a QMA or nurse that was on-call for the facility and the CNA had replied that there wasn't. CNA 7 indicated that she had called the Administrator, again, and was told there was no nurse or QMA available to administer medications until 6-6:30 a.m.

A handwritten Nurse Note, dated 7/9/21 at 6:30 a.m., indicated the resident had been medicated for discomfort and anxiety as ordered. The resident's family member was present and had indicated the resident had been restless all night.

A Hospice Communication Note, dated 7/9/21 at 6:32 p.m., indicated the resident was to be transported to inpatient hospice

services on this date for "unmanaged symptoms of restlessness and agitation".

On 9/1/21 at 2:31 P.M., the Health and Wellness Director from the sister facility was interviewed. She indicated there had not been a nurse or QMA working from 7/8 at 10:00 p.m. through 7/9/21 at 6:00 a.m. but that there should have been and the resident should've been administered her medications as ordered.

On 9/1/21 at 2:48 P.M., CNA 3 was interviewed. During the interview, she indicated she had been present and working the early morning hours of 7/9/21 and had been caring for Resident K. Resident K had been very restless and agitated and she nor the other CNA's had known what to do. They had called the Administrator who said to call hospice which the CNA's had done but the hospice nurse couldn't come right away and there was no one to administer medications. She indicated the CNA's had tried to call their sister facility to see if a nurse or QMA could come over and administer the medication but their phone calls hadn't been answered so they called the resident's family to see if she could come to the facility and help the resident relax. There had been no nurse or QMA present and working

	until 6:30 a.m. This State Residential finding relates to Complaint IN00361620.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE