STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT LAPORTE	2002 ANDREW AVE, LA PORTE, , 46350

(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 IN00365537, IN00365483, IN00363394, IN00363250 and IN00362396. Complaint IN00365537 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00365483 - Substantiated. State deficiency related to the allegations is cited at R0185. Complaint IN00363394 - Unsubstantiated due to lack of evidence Complaint IN00363250 - Unsubstantiated due to lack of evidence Complaint IN00362396 - Substantiated. State deficiency related to the allegations is cited at R0349.	R 0000		

	Survey dates: November 4 & 5, 2021 Facility number: 010890 Residential Census: 81 These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/16/21.			
R 0185	Physical Plant Standards - Noncompliance 410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission: (A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable	R 0185	**Complaint IN00365483** What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident B was provided was a new pendant on 11/5/2021. The new pendant was provided to resident B by the maintenance director and tested by the Maintenance Director and Resident Care Director. The staff was educated on reporting residents who are without a pendant to the Maintenance Director and Resident Care Director immediately. This education was completed by 11/15/2021. **How the facility will identify other residents**	11/05/2021

	mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in		**having the potential to be affected by the same deficient practice and what corrective action will be taken** The Resident Care Director and/or designee and nursing staff performed a facility pendant audit and no other residents were identified to have been affected by the alleged deficient practice. Completed on 11/6/2021. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.**	

	wheelchairs. Based on observation, interview, and record review, the facility failed to provide a method by which a resident may summon a staff person at any time for 1 of 7 residents reviewed for pendant call buttons. (Resident B) Finding includes: On 11/5/21 at 10:08 a.m., Resident B was observed in his room seated in his recliner. The resident did not have a call light pendant or any system to call for help within reach. There was a call light mounted to the wall in the resident's room, however, it was located across the room and out of the resident's reach when he was in his chair or bed. Interview with the resident on 11/5/21 at 10:23 a.m., indicated he called out for help when he needed it, but staff often didn't hear him. He liked to go to the dining room for lunch, but he needed assistance to transfer to his wheelchair. The resident indicated he had a pendant call light before, but "a man took it and never brought it back." Resident B's record was reviewed on 11/5/21 at 9:27 a.m. Diagnoses included, but were not limited to, Diabetes, high blood pressure and stroke. The resident receives hospice		Upon admission resident will be given a pendant by the Maintenance Director. The Maintenance Director will sign an audit sheet stating that a pendant was given to the resident and education provided on how to use it. The audit sheet will be given to the Resident care director. The care staff will also verify the resident has a pendant upon move in and sign off that the resident has a pendant and is able and knows how to use it. **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place** Pendant audit will be performed three times per week for one month and then weekly for three months, then quarterly thereafter to ensure all resident have pendants. The findings will be shared monthly through the QA process by the Resident care director. Any findings will be addressed immediately by the Resident care director.	

services.

The Level of Care assessment, dated 9/20/21, indicated the resident was totally dependent on staff for activities of daily living (ADL's), was forgetful and required occasional reminders and cueing.

The November 2021 Physician's Order Summary (POS), indicated the resident monitored his blood sugar three times daily. He also receives Lantus insulin every day at bedtime.

Nursing progress notes on 9/24/21, indicated the resident was found on the floor. A later Nursing Progress Note on 9/26/21 at 7:25 p.m., indicated the resident was again found on the floor.

On 10/20/21 (no time recorded), the hospice Progress Notes indicated there was no call light available. Hospice visited the resident 2 times weekly, increased from one time weekly on 10/1/21. Hospice staff communicated with the facility on what care was provided and his status upon leaving. The note was placed in the resident's record.

Interview with CNA 1 on 11/5/21 at 11:10 a.m. indicated the resident hadn't had a pendant call system for at least a couple of months. The previous Maintenance Supervisor was

notified and the front desk receptionist had been notified on numerous occasions.

Interview with QMA 1, on 11/5/21 at 1:35 p.m., indicated the resident was alert and oriented times 3 on most days and was able to make his needs known. She indicated the resident currently yelled out when he needed something.

This state residential finding relates to complaint IN00365483.

Based on observation, interview, and record review, the facility failed to provide a method by which a resident may summon a staff person at any time for 1 of 7 residents reviewed for pendant call buttons. (Resident B)

Finding includes:

On 11/5/21 at 10:08 a.m., Resident B was observed in his room seated in his recliner. The resident did not have a call light pendant or any system to call for help within reach. There was a call light mounted to the wall in the resident's room, however, it was located across the room and out of the resident's reach when he was in his chair or bed.

Interview with the resident on 11/5/21 at 10:23 a.m., indicated he called out for help when he needed it, but staff often didn't

hear him. He liked to go to the dining room for lunch, but he needed assistance to transfer to his wheelchair. The resident indicated he had a pendant call light before, but "a man took it and never brought it back."

Resident B's record was reviewed on 11/5/21 at 9:27 a.m. Diagnoses included, but were not limited to, Diabetes, high blood pressure and stroke. The resident receives hospice services.

The Level of Care assessment, dated 9/20/21, indicated the resident was totally dependent on staff for activities of daily living (ADL's), was forgetful and required occasional reminders and cueing.

The November 2021 Physician's Order Summary (POS), indicated the resident monitored his blood sugar three times daily. He also receives Lantus insulin every day at bedtime.

Nursing progress notes on 9/24/21, indicated the resident was found on the floor. A later Nursing Progress Note on 9/26/21 at 7:25 p.m., indicated the resident was again found on the floor.

On 10/20/21 (no time recorded), the hospice Progress Notes indicated there was no call light available. Hospice visited the resident 2 times weekly,

	increased from one time weekly on 10/1/21. Hospice staff communicated with the facility on what care was provided and his status upon leaving. The note was placed in the resident's record. Interview with CNA 1 on 11/5/21 at 11:10 a.m. indicated the resident hadn't had a pendant call system for at least a couple of months. The previous Maintenance Supervisor was notified and the front desk receptionist had been notified on numerous occasions. Interview with QMA 1, on 11/5/21 at 1:35 p.m., indicated the resident was alert and oriented times 3 on most days and was able to make his needs known. She indicated the resident currently yelled out when he needed something. This state residential finding relates to complaint IN00365483.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (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:	R 0349	**Complaint IN00362396** **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice.**	12/31/2021

(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, follow up, and assessment after falls, injuries and hospital visits for 2 of 3 residents reviewed for falls. (Residents B & C)

Findings include:

1. The record for Resident B was reviewed on 11/5/21 at 10:20 a.m. Diagnoses included, but were not limited to, dysphagia, stroke, atrial fibrillation, anemia, COPD (chronic obstructive pulmonary disease), high blood pressure, and a total hip replacement.

Nurses' Notes, dated 9/8/21 at 7:19 a.m., indicated the resident's POA (Power of Attorney) was notified in regards to the resident staying up all night, calling out for her mom and dad, knocking shelves over and breaking "knick knacks."

Nurses' Notes, out of sequence, dated 9/8/21 at 7:27 a.m., indicated the resident was up at 1:15 a.m., sitting out in the

The Resident Care Director and/or designee will perform a late
entry will be added to the resident’s medical records to with noted follow up
and documentation from the incident follow-up
documentation by the nurses and/or QMA. To be completed by 12/31/21.

**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**

The Resident Care Director and/or Designee will audit all incidents
from the past 60 days to determine which if any other residents could be
affected by the alleged deficient practice. The Resident Care Director and/or
Designee will provide in-service education to all nursing staff regarding
proper follow up, complete documentation and
assessments x5 days a week for 4
weeks. To be completed by 12/31/2021.

What measures will be put

	common area talking to a pillow. At approximately 3:15 a.m., was pounding on the entrance door calling out for her mom and dad. This writer gave the resident Tylenol for back pain. The resident would not stay in bed, so aide kept her up, dressed, and was given water to drink and some juice. Nurses' Notes, dated 9/8/21 at 9:17 a.m., indicated at approximately 8:25 a.m., patient was found on the floor in her living room sitting on her buttock with her back against the couch. The patient was assessed. She has a scratch on her right scalp with no hematoma noted. Patient stated she did not know how she fell and refused to be sent out to the hospital. Her son was notified and agreed not to send his mother to the hospital. Her vital signs were taken and the physician was notified. Nurses' Notes, dated 9/8/21 at 2:15 p.m., indicated the resident was talking to self and putting belongings in mouth and placing pictures and post cards in her bra. The resident was yelling and screaming during care. There was no documentation or assessment regarding the scratch to the back of the head. Nurses' Note, dated 9/9/21 at 3:34 a.m., indicated approximately at 12:00 a.m., the CNA called for assistance to the		**into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** The Resident Care Director and/or designees will audit all incidents for follow up, complete documentation, and assessments 5 days a week on a ongoing basis. **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place** The Resident Care Director and/or designee will perform daily audits and findings will be brought to the monthly quality assurance and performance improvement monthly x3 months until substantial compliance is achieved. To be completed by 03/31/22.	

resident's room. Observed resident lying on her back in the middle of the living room in her apartment. Her items of personal value were broken up and personal pictures observed in the waste basket. Assessed the resident for any reddened, deformed or open areas or bruising. The resident yelled out in pain with assistance up to feet, that her back hurts. The resident had an abrasion on her left inner forearm approximately 1.5 inches by 1/2 inch. First aide of cleaning the area and applying non adherent dressing with Bacitracin ointment and secured with tape was completed. Assisted the resident to bed and vital signs were taken. The physician and Director of Nursing (DON) were notified.

Nurses' Notes, dated 9/9/21 at 7:35 a.m., indicated the son was notified of fall at this time. There was no assessment or follow up regarding the scratch to her head or the new abrasion to the left arm.

Nurses' Notes on 9/9/21 at 10:45 a.m., indicated the patient was knocking over items in her room and was confused. The son and physician were notified and new orders were obtained to send out to the hospital.

Nurses' Notes, dated 9/9/21 at 2:50 p.m., indicated the patient

was sent to hospital and was returned.

Follow up entries in Nurses' Notes were on 9/11/21 at 3:00 p.m., 9/12/21 at 5:10 a.m., and 9/13/21 at 10:00 p.m., and there was no information or follow up assessment regarding the abrasion to the left forearm or the scratch to the resident's head.

Interview with the DON 11/5/21 at 12:00 p.m., indicated there was no follow up documentation after each fall, no assessment done, and no neuro checks completed after the scratch to the head "because it was undetermined if she hit her head or not." There was also no follow up after the abrasion was obtained from the 9/9/21 fall.

2. The record for Resident C was reviewed on 11/5/21 at 9:30 a.m. Diagnoses included, but were not limited to, high blood pressure, heart failure, COPD, muscle weakness, abnormal gait and mobility, and dementia.

An Emergency Room (ER) visit report, dated 8/29/21, indicated the patient was treated and seen for a hand contusion.

A communication to the physician, dated 8/29/21, indicated the resident went to the hospital for pain and swelling to her right wrist after

self reporting a fall that she had last night. The resident was denying pain or discomfort at this time.

Nurses' Notes, dated 9/1/21 at 5:20 a.m., indicated the resident had not complained of any pain or discomfort to the right hand or thumb. The hand and thumb were swollen and an ace bandage was wrapped around the area. The resident self reported this fall as it was unwitnessed.

The next documented entry in Nurses' Notes, was 9/25/21 and there was no follow assessment or documentation regarding the swollen hand and thumb.

Nurses' Notes, dated 10/25/21 at 8:45 p.m., indicated the resident lost her balance and fell in the apartment. There were no complaints of pain and no injuries noted. Vital signs obtained and the daughter and physician were notified.

The next entry in Nurses' Notes, was on 10/27/21 at 6:30 p.m., which indicated the resident was not bearing weight and had complaints of pain to head and lower abdomen. A telephone order from the doctor was obtained to send to the hospital for an evaluation.

Nurses' Notes, dated 10/27/21 at 11:00 p.m., indicated the hospital called and the resident

was being admitted with a left pubic ramis fracture, urinary tract infection and renal failure.

There was no follow up assessment or documentation of the resident completed after the fall.

Exception Charting provided by the DON on 11/5/21 at 12:00 p.m.., indicated additional documented information from nursing staff as follows:

On 10/27/21 (no time) the resident walked into a pillar and hit right hand, fell and bruised right hand. A skin tear to the left forearm was sustained. At 6 p.m., complains of head and lower abdominal pain and was unable to bear weight.

The above fall had not been documented in the Nurses' Notes on 10/27/21.

Interview with the DON at that time, indicated Exception Charting was not part of the resident's clinical record. There was no follow up assessment or documentation after each fall or of the swollen wrist.

This state residential finding relates to complaint IN00362396.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately

documented related to lack of documentation, follow up, and assessment after falls, injuries and hospital visits for 2 of 3 residents reviewed for falls. (Residents B & C)

Findings include:

1. The record for Resident B was reviewed on 11/5/21 at 10:20 a.m. Diagnoses included, but were not limited to, dysphagia, stroke, atrial fibrillation, anemia, COPD (chronic obstructive pulmonary disease), high blood pressure, and a total hip replacement.

Nurses' Notes, dated 9/8/21 at 7:19 a.m., indicated the resident's POA (Power of Attorney) was notified in regards to the resident staying up all night, calling out for her mom and dad, knocking shelves over and breaking "knick knacks."

Nurses' Notes, out of sequence, dated 9/8/21 at 7:27 a.m., indicated the resident was up at 1:15 a.m., sitting out in the common area talking to a pillow. At approximately 3:15 a.m., was pounding on the entrance door calling out for her mom and dad. This writer gave the resident Tylenol for back pain. The resident would not stay in bed, so aide kept her up, dressed, and was given water to drink and some juice.

Nurses' Notes, dated 9/8/21 at

9:17 a.m., indicated at approximately 8:25 a.m., patient was found on the floor in her living room sitting on her buttock with her back against the couch. The patient was assessed. She has a scratch on her right scalp with no hematoma noted. Patient stated she did not know how she fell and refused to be sent out to the hospital. Her son was notified and agreed not to send his mother to the hospital. Her vital signs were taken and the physician was notified.

Nurses' Notes, dated 9/8/21 at 2:15 p.m., indicated the resident was talking to self and putting belongings in mouth and placing pictures and post cards in her bra. The resident was yelling and screaming during care. There was no documentation or assessment regarding the scratch to the back of the head.

Nurses' Note, dated 9/9/21 at 3:34 a.m., indicated approximately at 12:00 a.m., the CNA called for assistance to the resident's room. Observed resident lying on her back in the middle of the living room in her apartment. Her items of personal value were broken up and personal pictures observed in the waste basket. Assessed the resident for any reddened, deformed or open areas or bruising. The resident yelled out in pain with assistance up to feet, that her back hurts. The

resident had an abrasion on her left inner forearm approximately 1.5 inches by 1/2 inch. First aide of cleaning the area and applying non adherent dressing with Bacitracin ointment and secured with tape was completed. Assisted the resident to bed and vital signs were taken. The physician and Director of Nursing (DON) were notified.

Nurses' Notes, dated 9/9/21 at 7:35 a.m., indicated the son was notified of fall at this time. There was no assessment or follow up regarding the scratch to her head or the new abrasion to the left arm.

Nurses' Notes on 9/9/21 at 10:45 a.m., indicated the patient was knocking over items in her room and was confused. The son and physician were notified and new orders were obtained to send out to the hospital.

Nurses' Notes, dated 9/9/21 at 2:50 p.m., indicated the patient was sent to hospital and was returned.

Follow up entries in Nurses' Notes were on 9/11/21 at 3:00 p.m., 9/12/21 at 5:10 a.m., and 9/13/21 at 10:00 p.m., and there was no information or follow up assessment regarding the abrasion to the left forearm or the scratch to the resident's head.

Interview with the DON 11/5/21 at 12:00 p.m., indicated there was no follow up documentation after each fall, no assessment done, and no neuro checks completed after the scratch to the head "because it was undetermined if she hit her head or not." There was also no follow up after the abrasion was obtained from the 9/9/21 fall.

2. The record for Resident C was reviewed on 11/5/21 at 9:30 a.m. Diagnoses included, but were not limited to, high blood pressure, heart failure, COPD, muscle weakness, abnormal gait and mobility, and dementia.

An Emergency Room (ER) visit report, dated 8/29/21, indicated the patient was treated and seen for a hand contusion.

A communication to the physician, dated 8/29/21, indicated the resident went to the hospital for pain and swelling to her right wrist after self reporting a fall that she had last night. The resident was denying pain or discomfort at this time.

Nurses' Notes, dated 9/1/21 at 5:20 a.m., indicated the resident had not complained of any pain or discomfort to the right hand or thumb. The hand and thumb were swollen and an ace bandage was wrapped around

the area. The resident self reported this fall as it was unwitnessed.

The next documented entry in Nurses' Notes, was 9/25/21 and there was no follow assessment or documentation regarding the swollen hand and thumb.

Nurses' Notes, dated 10/25/21 at 8:45 p.m., indicated the resident lost her balance and fell in the apartment. There were no complaints of pain and no injuries noted. Vital signs obtained and the daughter and physician were notified.

The next entry in Nurses' Notes, was on 10/27/21 at 6:30 p.m., which indicated the resident was not bearing weight and had complaints of pain to head and lower abdomen. A telephone order from the doctor was obtained to send to the hospital for an evaluation.

Nurses' Notes, dated 10/27/21 at 11:00 p.m., indicated the hospital called and the resident was being admitted with a left pubic ramis fracture, urinary tract infection and renal failure.

There was no follow up assessment or documentation of the resident completed after the fall.

Exception Charting provided by the DON on 11/5/21 at 12:00 p.m.., indicated additional

	documented information from nursing staff as follows: On 10/27/21 (no time) the resident walked into a pillar and hit right hand, fell and bruised right hand. A skin tear to the left forearm was sustained. At 6 p.m., complains of head and lower abdominal pain and was unable to bear weight. The above fall had not been documented in the Nurses' Notes on 10/27/21. Interview with the DON at that time, indicated Exception Charting was not part of the resident's clinical record. There was no follow up assessment or documentation after each fall or of the swollen wrist. This state residential finding relates to complaint IN00362396.			

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