STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/14/2022

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 Complaint IN00372375. Complaint IN00372375 - Substantiated. State deficiencies related to the allegations are cited at R036. Survey date: February 14, 2022 Facility number: 010890 Residential Census: 72 This State Residential Finding was cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/18/22.	R 0000		
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:	R 0036	**1.** **Clinical Staff will adhere to ISL Policy** GP 05 – Resident Assessment and Service Plan	04/30/2022

(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.

Based on record review and interview, the facility failed to ensure the Physician was notified in a timely manner following a change in condition for 1 of 3 residents reviewed for death. (Resident E)

Finding includes:

The record for Resident E was reviewed on 2/14/22 at 11:40 a.m. Diagnoses included, but were not limited to, dementia.

An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated and upon a known substantial change in the resident's condition, or more often at the resident's or facility's request. A licensed nurse shall evaluate the nursing needs of the resident.

2. Nurse/QMA will adhere to ISL Policy GP 18 – End of Shift Reporting

All caregivers and medication staff will document at the end of each shift.

3. **New Hire and Ongoing Resident Rights In-service for all ISL Associates**

Perform resident Rights in-service for current associates and new hires.

The facility must immediately consult the resident's physician and the resident's legal representative when the facility has noticed a significant decline in the resident's physical, mental, or psychosocial status; or a need to alter

Nurses' Notes, dated 12/20/21 at 3:07 a.m., indicated it was reported to the nurse that the resident was unresponsive. The resident was not talking and was not combative when incontinence care was provided. His eyes were open and his skin color was pale. His blood pressure was 103/58 (normal 120/80), pulse 56 (normal 60 to 100 beats per minute), temperature 96.1, and 96% oxygen saturation on room air. Documentation indicated the resident would continue to be monitored.

The next documented entry in the nursing progress notes was completed by a QMA at 6:08 a.m., three hours later, which indicated the resident was unresponsive to the CNA that morning and he was not acting like his normal self. His skin was pale and warm to touch. The nurse was called to the unit and the resident was assessed. His blood pressure was 103/58, pulse 56, temperature 96.1, and pulse oximeter was 96%.

The next documented entry in the nursing progress notes was at 10:55 a.m. The entry indicated the QMA notified the nurse the resident was unresponsive, his eyes were open, but he was nonresponsive. The Physician was notified the resident was being sent to the emergency

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.

1.
Residents who reside in Assisted Living will be re-assessed:

2.
30 days after move-in.

3.
Every six months.

4.
Whenever there is significant change in resident condition.

5.
Notify Physician via phone and/or using the communication form of any resident condition changes.

End of Shift Reporting performed as follows:

1. At the end of each shift, the Nurse/QMA
reviews the end of shift charting from care staff. A report is provided to the on-coming Nurse/QMA using the Nurse/QMA to Nurse/QMA Communication Log.

	room and a voicemail was left for his family. An entry completed by the Generations Program Director, on 12/20/21 at 11:24 a.m., indicated she was approached by the QMA who reported the resident was not responding per his "usual" and requested the writer initiate contact to behaviorally assess. A wellness check was completed immediately following the QMA's report. The resident was laying on his bed, fully clothed, and covered with blankets. The resident was not responsive when his name was called. His eyes were open but he was not able to make eye contact and his eyes were noted to roll back into his head. The resident's tongue was observed to be protruding from his lips. Direct care attendant at writer's side indicated a significant change in the resident's current condition. Clinical staff were encouraged to contact 911 and provide communication to his attending Physician. Clinical staff completed follow up contacts. The resident was currently en route to acute care via 911 transport. At 2:51 p.m., documentation indicated the resident was sent from the local emergency room to another hospital in the area with the diagnoses of stroke and seizures.		2. The Nurses/QMAs communicate at the end of shift any pertinent medication information such as reported refusals, new orders, medications on hold, physician communication, labs, abnormal labs not acted on, change in status, or other concerns, using the Nurse/QMA to Nurse/QMA Communication Log. **<u>Alert Charting</u>** 1. The alert charting process includes: a) The resident’s name and concern will be placed in a discreet location readily visible to care staff or alert charting reminder is turned on in the service planning program. b) Each resident placed on alert charting will be monitored for at least 48 hours following the initiation of alert charting. The Resident Care Director or designee will assign alert charting responsibilities and monitor the alert charting on a daily basis.	

Interview with the Executive Director on 2/14/22 at 1:45 p.m., indicated the Physician should have been notified in a more timely manner about the resident's change in condition at 3:00 a.m.

This State Residential finding relates to Complaint IN00372375.

Based on record review and interview, the facility failed to ensure the Physician was notified in a timely manner following a change in condition for 1 of 3 residents reviewed for death. (Resident E)

Finding includes:

The record for Resident E was reviewed on 2/14/22 at 11:40 a.m. Diagnoses included, but were not limited to, dementia.

There is to be an alert charting entry in the
resident record each shift.

c) Care staff will immediately notify the
Resident Care Director or designee if the resident is exhibiting a change in condition or other reason for concern.

d) The Resident Care Director will evaluate the
resident prior to determining if the resident may be removed from alert
charting.

Changes in the
resident’s Service Plan will be made, as appropriate.

All change in conditions will be discussed and address at the daily clinical meeting in the presence of the clinical care team and executive director for the next 30-days.

RELIAS
TRAINING & SELF STUDY
RESIDENT RIGHTS
IN-SERVICE

1.
New associates upon hire and

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room and a voicemail was left for his family.

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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