STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKDALE FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00419400. Complaint IN00419400 - Deficiencies related to the allegations are cited at R0036, R0247, and R0248. Survey date: October 24, 2023 Facility number: 003273 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Qaulity review completed October 26, 2023	R 0000	The following is the Plan of Correction for Brookdale Fort Wayne regarding the Statement of Deficiencies dated 10/24/2023. This 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 any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective	
R 0036 Bldg. 00	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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tonya Bollin	Health & Wellness Director	11/07/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	commence a new form of treatment. Based on observation, interview and record review, the facility failed to notify the physician of a significant change in condition for 2 of 3 residents reviewed (Resident H and Resident K). Findings include: 1. On 10/24/23 at 10:48 A.M., Resident H's family member was interviewed. They expressed concern with the resident's condition observed on 10/6/23 and 10/9/23. The family member indicated the resident had been observed on both days to be "dehydrated" and having difficulty drinking from a cup. He had been sleepy and not responding to family members which was reported to staff. The family member indicated Resident H ended up being hospitalized for dehydration and alleged he had been over-medicated with anti-psychotic medications. On 10/24/23 at 11:16 A.M., Resident H's record was reviewed. Diagnoses included dementia, localized edema, and other mental disorders due to known physiological condition. The resident admitted to the secured memory care unit of the facility following hospitalization for medication adjustments. Admission orders, dated 8/31/23, were for the resident to receive Olanzapine (anti-psychotic) 2.5 milligrams (mg) by mouth 2 times per day for dementia. A Personal Service Plan, dated 10/5/23 at 5:07 p.m., indicated the resident required assistance and administration of medications; he was able to perform dressing, grooming, and bathing activities with assistance if needed; required reminders to toilet every 2-4 hours; used a walker, was at high risk for falls; was not always oriented to person, place, or time; and required behavior management	R 0036	R036 Residents Rights: 1 Resident H was sent out to the hospital on 10/9/23 and didn't return to the community. Resident K was sent to the hospital on 10/24/23 and returned to the community. The Health and Wellness Director provided coaching on (date) to the QMA regarding notification of the nurse and/or Health and Wellness Director for a changeof condition for Resident H and Resident K. The Health and Wellness Director re-educated the QMA on the Change of Condition Policy on 11/6/2023. 2 All residents have the potential to be affected. The Health and Wellness Director will audit residents' charts to identify any change of conditions from the past 3 months to verify the doctor and the responsible party was notified. 3 Nursing staff to be re-educated on the Change of Condition Policy by the Health and Wellness Director on 11/6/2023 and 11/14/2023. The Health and Wellness Director and /or designee will check the shift report daily Monday through Friday to identify any changes in residents' conditions and verify the doctor and responsible party were notified. 4 The Health and Wellness Director and/or designee will report	11/17/2023

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	for attempts to exit the facility unsupervised. A Move In note, dated 8/31/23 at 5:00 p.m., indicated the resident arrived at the facility from the hospital. He was alert and oriented to person, walked with a walker but was unsteady at times. He was on a regular diet. He had pitting edema to both lower legs. A Nurse Practitioner (NP) progress note, dated 9/27/23 at unknown time, indicated the resident had been seen for management of chronic lower leg edema. The resident's spouse expressed concern his edema was getting worse and was concerned because of his history of kidney disease. She indicated she hadn't noticed the resident going to the bathroom as often. New orders were given to increase the resident's Lasix (diuretic/water pill) from 40 mg to 60 mg by mouth daily and obtain blood work the following week to check his electrolytes, kidney function, and magnesium level. A Progress Note, dated 9/28/23 at 1:42 p.m., indicated the resident's spouse wanted to know why his 8:00 p.m. medication was making him sleepy when she visited. The spouse wasn't sure which medication was making the resident sleepy. There was no follow up to the spouse's concern documented. A Behavior Note, dated 10/3/23 at unknown time, indicated the resident had been visited by the psychiatric NP. He was seen for assessment of medications and insomnia. Staff reported concerns with his behaviors. He had no reported appetite changes, pain, or change in sleeping pattern. During the visit, the resident was cooperative and pleasantly confused with no reported agitation or behaviors. The treatment		any change of conditions and notifications of doctor and responsible party in the daily stand up meeting Monday through Friday. Any issues identified will be addressed with the individual associate. The Health and Wellness Director and/or designee will audit 5 resident charts weekly for 2 months, then monthly for 4 months to verify any change of conditions were reported to the doctor and the responsible party. D Date of compliance 11/6/2023 **11/**	

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	plan was to continue his anti-psychotic medication. There was no documentation to indicate the psych NP had been notified of the spouse's concern with his increased sleepiness. A lab report, dated 10/4/23, indicated the following: low overall kidney function at 31.3-normal >59; BUN (blood urea nitrogen-kidney function) at 44-normal <23; Creatinine 1.98-normal <1.3; and sodium at 146-normal <145. There was no documentation to indicate the physician or family had been notified of the abnormal lab results. A Progress Note, dated 10/8/23 at 12:48 p.m., indicated the QMA (Qualified Medication Aid) had entered the resident's room around 9:00 a.m. to give him his medications. The resident was asleep in bed. The spouse asked the resident's medications not be given because he was too sleepy and indicated she would speak with the Health and Wellness Director (HWD) the following day about his medications. A Progress Note, dated 10/9/23 at 11:29 a.m., indicated the QMA had been told Resident H had not allowed staff to change him and provide care. She was told the resident's wife had been in the resident's room early in the morning and had requested he not be given his medications until the resident's spouse spoke with the HWD. After breakfast, the resident's wife told the QMA she was calling 911 because the resident wasn't acting right. The resident was sent to the hospital per family request. On 10/24/23 at 1:41 P.M., the HWD was interviewed. She indicated staff should have notified the physician of the resident's abnormal lab report on 10/4/23. She indicated staff were to			

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	monitor for changes in behavior and medical condition and notify the physician of changes. 2. On 10/24/23 at 10:05 A.M., Resident K was observed in the lobby of the facility on a guerney for transport to the hospital by EMS. She was alert and smiling at staff but held the left side of her head with her hand. An unknown staff member was overheard telling EMS personnel the resident was more confused than usual and had fallen a few days before. On 10/24/23 at 3:30 P.M., Resident K's record was reviewed. Diagnoses included Alzheimer's dementia, anxiety disorder, and depression. An unsigned Personal Service Plan, dated 7/3/23, indicated the resident resided on the secured memory care unit due to memory loss and wandering. She ambulated independently, required cues, reminders for meal times and activities. She required set up with laying out her clothes and grooming toiletries but required no bathroom assistance. She had some reluctance with accepting assistance with showering/bathing. She had no other behaviors nor was she on a behavior management program. A progress note, dated 10/10/23 at 5:45 a.m., indicated staff had heard a loud noise in the resident's room. The resident had turned her dresser over. There was no further documentation completed on the unusual behavior nor was the physician notified. A Progress Note, dated 10/20/23 at 8:43 a.m., indicated the resident had been found on the floor wedged between the foot of the bed and the end			

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	table with her left arm wedged through the back of the table. She was on her knees with her head in the wall, her face in the frame of the bed and had soiled herself. The resident was cleaned up and range of motion checked to her legs and arms. She was assisted to stand and walked with staff to her bed where she laid down. -At 7:55 p.m., the resident had no complaints of pain but was unsteady to ambulate to supper. She was placed in a wheelchair and taken down to the dining room where she ate 75% of her meal. She required assistance with personal care and getting into bed. A Progress Note, dated 10/21/23 at 8:56 p.m., stated "no issues". There was no documentation completed on 10/22/23 regarding pain or assistance needed. On 10/23/23 at 12:06 a.m., a Progress Note indicated the resident had been in her apartment sitting on her sofa, leaning to the right. When asked to sit up, the resident replied her legs hurt. When assisted to a sitting position, she "wouldn't or couldn't" sit up. She had been able to sit upright that morning without difficulty. She appeared very fatigued and would continue to be monitored. -At 9:37 a.m., the resident was leaning to the right side of her body. When asked to sit up straight, she replied yes but wouldn't sit up. When assisted to sit up, the resident would lean back over to the right side. -At 1:32 p.m., the resident's daughter was notified the resident wasn't acting like herself and kept leaning to the side. She denied pain and indicated she felt fine. Her daughter was asked if she wanted her sent to the hospital for evaluation and the daughter indicated not at this time.			

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	A Progess Note, dated 10/24/23 at 12:02 a.m., indicated the resident was incontinent of bowel and bladder when assisted up from the couch. This was new for her. Additionally, she had required assistance of 2 staff for transfers. A progress note, dated 10/24/23 at 8:43 a.m., indicated the resident was assessed by the Health and Wellness Director who determined the resident needed sent out to the ER for evaluation. The resident was leaning to the side, complained of left lower leg pain, and hadn't been eating. There was no documentation to indicate the physician had been notified of the fall and how the resident had been found. On 10/24/23 at 3:51 P.M., the Health and Wellness Director (HWD) was interviewed. She indicated she hadn't been notified of the resident's behavior on 10/10/23. She indicated the resident hadn't ever had behaviors like that and the physician should have been notified. When asked about the resident's fall, the HWD indicated the physician should have been notified of the fall, how the resident had been found and changes in her condition following the fall. When asked, the HWD didn't know if Resident K's daughter had been notified of the resident's fall or not. The HWD indicated the resident remained at the hospital and following a scan of her head, was found to have a mild brain bleed. A current facility policy, titled "Change of Condition", stated: "A change of condition should be evaluated and documented for residents who exhibit significant deviation in physical or mental status such as: change in medical condition, change in behavior, change in cognitive ability...Emergent: residents with			

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	unstable or potentially life threatening medical or mental health conditions should be evaluated by a physician/healthcare provider (HCP) or sent to the emergency department...Non-Emergent: the physician/HCP and legally responsible party should be notified of resident's change of condition. All necessary medical care and treatment measures should be initiated and provided at the direction of the physician/HCP...." This citation relates to Complaint IN00419400.			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to notify the physician of a medication error for 1 of 3 residents reviewed (Resident H). Findings include: On 10/24/23 at 10:48 A.M., Resident H's family member was interviewed. They expressed concern with the resident's change in condition. The family member indicated the resident had been prescribed an anti-psychotic medication, Olanzapine. The family member alleged, while at the hospital, family were told the resident shouldn't have been on this medication due to the resident's diagnosis of dementia. He alleged the resident had been hospitalized due to dehydration and over-medication from anti-psychotic medications. On 10/24/23 at 11:16 A.M., Resident H's record	R 0247	R247 Health Services Deficiency 1 Resident H was sent out to the hospital on 10/9/23 and didn't return to the community. The Health and Wellness Director will provide coaching on (date) to the associates responsible for transcription of the physician order. The Health and Wellness Director re-educated the associates on the Medications and Treatments-Medication Error Policy which includes documentation in the resident record and notification of the doctor and resp1nd Wellness Director and/or designee to audit residents' charts for the past three months for any medication documentation discrepancies.	11/17/2023

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	was reviewed. Diagnoses included dementia, localized edema, and other mental disorders due to known physiological condition. The resident admitted to the secured memory care unit of the facility following hospitalization for medication adjustments. Admission orders were for the resident to receive Olanzapine (anti-psychotic) 2.5 milligrams (mg) by mouth 2 times per day for dementia. A physician order, dated 9/14/23 at unknown time, was for an additional 1 time dose of Olanzapine 5 mg by mouth and start Risperdal (anti-psychotic) 0.5 mg by mouth 2 times per day. Olanzapine 2.5 mg 2 times per day was to continue until Risperdal was received by the facility, then Olanzapine was to be discontinued. A Medication Administration Record (MAR) dated September 2023, indicated Olanzapine 2.5 mg was administered to the resident at 8:00 a.m. and 8:00 p.m. every day until it was discontinued on 9/21/23. The MAR indicated Risperdal 0.5 mg was received from the pharmacy and started on 9/16/23 at 9:00 a.m. and continued for the rest of the month. Olanzapine 2.5 mg was not discontinued per physician order when the Risperdal 0.5 mg was started on 9/16/23. The resident received both Olanzapine 2.5 mg and Risperdal 0.5 mg 9/16/23 through 9/20/23. Interactions between Olanzapine and Risperdal was retrieved from the mobile Physician's Desk Reference on 10/24/23 at 4:00 P.M. The reference indicated use of the 2 medications together could cause irregular heart beat, drowsiness, confusion, flushing, abdominal cramping, blurred vision, dry mouth and difficulty urinating. On 10/24/23 at 3:00 P.M., the Health and Wellness		3 Nursing staff to be re-educated on Medications and Treatments-Medication Error Policy by the Health and Wellness Director on 11/06/2023. Any aberrancy identified to be put on the shift report. 4 The Health and Wellness Director and/or designee will check the shift report daily Monday through Friday to identify any medication documentation inconsistencies and verify it was documented in the resident's medical record and the doctor and responsible party were notified. The Health and Wellness Director and /or designee will review and report medication documentation discrepancies in the daily stand up meeting Monday through Friday. Any issues identified will be addressed with the individual associate. The Health and Wellness Director and/or designee will audit 5 resident charts weekly for 2 months then monthly for 4 months to verify if any medication documentation discrepancies that it was documented in the resident's chart and reported to the doctor and responsible party. 5 11/7/2023	

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	Director was interviewed. She indicated administration of both Olanzapine and Risperdal together was a medication error according to the resident's physician orders. She indicated the medication error and notification to the physician and family should have been completed and documented in the resident's record. A current policy, provided on 10/24/23 at 3:05 P.M. and titled "Medications and Treatments-Medication Error", stated: "Associates providing, assisting or administering medication to residents are expected to follow the 7 rights of medication administration...If a medication error occurs, the nurse/designee is responsible for reporting the medication error to the prescribing physician/healthcare provider (HCP), the resident, the legally responsible party...." This citation relates to Complaint IN00419400.			
R 0248 Bldg. 00	410 IAC 16.2-5-4(f) Health Services - Deficiency (f) The facility shall have available on the premises or on call the services of a licensed nurse at all times. Based on interview and record review, the facility failed to have a licensed nurse available to complete an admission for 1 of 3 residents reviewed (Resident H). Findings include: On 10/24/23 at 11:16 A.M., Resident H's record was reviewed. Diagnoses included dementia, localized edema, and other mental disorders due to known physiological condition. The resident admitted to the secured memory care unit of the facility following hospitalization for medication	R 0248	R 248 Health Services Deficiency 1 Resident H was sent out to the hospital on 10/9/23 and didn't return to the community. The QMA was counseled by the Health and Wellness Director on notifying the Executive Director if no nurse is available in person and the Health and Wellness Director is off on 11/6/2023. 2 All residents have the	11/07/2023

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	adjustments. Resident H's Admission Orders and Plan of Care form provided by the Health and Wellness Director (HWD) on 10/24/23 at 3:05 P.M. dated 8/31/23, indicated the orders had been verified with the physician. The signature of the person who completed the form was not a nurse, but a QMA (Qualified Medication Aid). On 10/24/23 at 3:00 P.M., the Health and Wellness Director was interviewed. She indicated a licensed nurse was responsible for receiving, writing, and verifying verbal, telephone and written physician orders. She had been on a leave of absence when Resident H was admitted to the facility and wasn't sure why the QMA signed off on the admission orders. On 10/24/23 at 3:12 P.M., QMA 3 was interviewed. She indicated there had not been a licensed nurse available the day Resident H was admitted and had tried to do the best she could by writing down the orders sent from the hospital. This citation relates to Complaint IN00419400.		potential to be affected. QMAs will be educated on notifying the Executive Director if there is no nurse available in person and the Health and Wellness Director is off on 11/6/2023 and 11/14/2023. 3 The Executive Director and/or designee will review the schedule during the daily stand up meeting Monday through Friday to verify there is a nurse available to the QMAs' either in person or by phone. 4 The Executive Director to complete 3 random audits monthly for 6 months to interview QMAs to verify they know what to do if there isn't a nurse available in person or by phone. 11/7/2023 !--[if !supportAnnotations]-->	