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	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT ELKHART ASSISTED LIVING	3109 E BRISTOL ELKHART, IN 46514

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: June 12 and 13, 2024 Facility number: 010065 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 6/21/2024	R 0000	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. This plan of correction is being submitted as required by the regulation. The provider respectfully requests a desk review with paper compliance to be considered.	
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on record review and interview, the facility failed to inform the physician of blood sugars out of ordered parameter range for 1 of 9 residents reviewed for health services. (Resident 6) Finding includes: A record review for Resident 6 was completed on 6/12/2024 at 11:10 A.M. Diagnoses included, but were not limited to, diabetes mellitus type 2, chronic kidney disease, and dementia. A Physician's Order, dated 3/26/2024, indicated Resident 6 was to receive insulin aspart (Novolog)	R 0242	One resident was found to have been affected by the deficient practice, but all residents have the potential to affected. All residents that require blood glucose monitoring could have been affected. An audit of all resident's receiving insulin was completed to ensure orders are being carried out as written. All nurses and insulin certified QMA's will be educated on following insulin orders and documenting correctly including	07/23/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Ciak	VP of Operations	07/05/2024

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	before meals and at bedtime per the sliding scale, and the facility was to notify the physician for blood sugars less than 80 mg/dL or greater than 400 mg/dL. Tthe following blood sugar results were recorded for Resident 6: -On 6/9/20224 at 8:03 P.M the resident's blood sugar level was 65. -On 6/8/2024 at 7:46 A.M. the resident's blood sugar level was 67. -On 6/7/2024 at 8:14 A.M.the resident's blood sugar level was 66. -On 6/6/2024 at 11:28 A.M.the resident's blood sugar level was 66. -On 5/27/2024 at 7:47 A.M.the resident's blood sugar level was 65. -On 4/30/2024 at 7:42 A.M.the resident's blood sugar level was 57. -On 4/25/2024 at 7:42 A.M.the resident's blood sugar level was 66. -On 4/18/2024 at 7:48 A.M.the resident's blood sugar level was 56. -On 4/18/2024 at 11:18 A.M.the resident's blood sugar level was 67. -On 4/16/2024 at 7:49 A.M.the resident's blood sugar level was 67. -On 4/15/2024 at 7:57 A.M.the resident's blood sugar level was 55. -On 4/12/2024 at 1:58 P.M.the resident's blood sugar level was 64. -On 4/2/2024 at 7:53 A.M.the resident's blood sugar level was 69. During an interview, on 6/13/2024 at 11:54 A.M., the Director of Nursing indicated the nursing staff had made errors and had not notified the physician of the lower blood sugar levels and the physician should have been notified.		notifying PCP/MD, affected resident, and family abnormalities by 7/23/2024. DON or designee will complete insulin audits twice weekly for 30 days then weekly for 60 days, then monthly for 90 days to ensure orders are being carried out as written. Education and disciplinary action will be taken when needed.	

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	A policy was provided, on 6/13/2024 at 1:52 P.M. by the Director of Nursing. The policy titled, "Policy for Transcription and Compliance with Physician Orders", indicated, " ...To ensure proper communication and consistent medication administration for residents, upon accepting orders from a physician ...If an order has been implemented correctly but the order is disregarded, or not followed, the staff responsible will be disciplined, up to and including termination ...Compliance with the physician's order will be documented on the MAR/TAR [Medication Administration Record/Treatment Administration Record] for the duration of the order. ..."			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure PRN (as needed) medications administered by a QMA (Qualified Medication Aide) were approved by a licensed nurse for 1 of 8 residents reviewed for medications. (Resident 3) Finding includes: The closed record for Resident 3 was reviewed on 6/12/2024 at 11:16 A.M. Diagnoses included, but were not limited to: depression, diabetes and hypertension.	R 0246	One resident was affected by this deficiency. All residents that have prn orders had the potential to be affected. An audit will be completed on all administered PRN medications ensuring correct documentation. All nursing staff will be educated on how to correctly administer PRN medications including documentation by 7/23/2024.	07/23/2024

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	Resident 3's medication orders included: Lorazepam (an antianxiety) 0.5 mg (milligram) 1 tablet every 4 hours (PRN) as needed for anxiety or restlessness, and morphine (a narcotic) 0.25 ml (milliliters) every 4 hours as needed for pain or air hunger. During an interview, on 6/23/2024 at 11:49 A.M, the Director of Nursing indicated QMAs were to document (the approval from a licensed nurse) in the electronic medication administration record (EMAR) when a PRN medication was given. The Medication Administration Record (MAR) for April indicated the resident was administered the Lorazepam medication on 4/8 and 4/23, and received the morphine medication on 4/18/2024 from QMA 4 with no documentation of an approval from the licensed nurse. The Nurses's Notes, dated 4/8, 4/18 and 4/23/2024, lacked the documentation the PRN medications had been approved by a licensed nurse prior to administration. During an interview, on 6/23/2024 at 12:45 P.M., the Director of Nursing indicated the QMA should have documented the approval from the nurse. On 6/13/2024 at 4:10 P.M., the Director of Nursing provided an undated paper from the pharmacy, and indicated this was what the facility followed.. The paper indicated "...Responsibility cont...A licensed nurse is responsible for the pre/post assessment and the documentation of all PRN's. Keep in mind a QMA/CMT/Med tech. can not assess and will need/require a co-signer with prn medications...."		An audit will be completed on all administered PRN medications twice weekly for 30 days, then once weekly for 30 days, then monthly for 90 days. Audits will include education and disciplinary action as needed.	

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R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interview, the facility failed to ensure Pharmacy regimen reviews were followed up on timely for 2 of 8 residents whose records were reviewed for Pharmacy recommendations. (Residents 3 & 4) Findings include: 1. A Pharmacy Recommendation form for Resident 3, dated 3/3/204, was reviewed on 6/13/2024 at 1:29 P.M. The form indicated to evaluate and consider tapering off Pantoprazole (stomach acid reducer) 40 mg (milligram) medication. If Pantoprazole was continued a risk versus benefit analysis for clinical rationale was requested. The response section and comments for the prescriber to agree, disagree and /or other were all blank and there were no documented comments. Resident 3's current Physician Orders indicated the resident was still receiving the Pantoprazole 40 mg medication. During an interview, on 6/13/2024 at 3:19 P.M., the Director of Nursing indicated the pharmacy recommendation should have been followed up on timely. 2. The record for Resident 4 was reviewed on 6/12/2024 at 11:16 A.M. A Pharmacy Recommendation form, dated 9/3/2023, indicated there was a duplication of	R 0299	2 residents were affected by this deficiency. All residents that received recommendations by the pharmacy had the potential to be affected. An audit of all pharmacy recommendations was completed on 6/25/2024. All missing recommendations were obtained and completed as ordered. A pharmacy recommendation audit will be completed every other month to ensure the facility obtains the recommendations and orders are carried out as written. This will be done indefinitely.	07/23/2024

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	therapy with 2 PRN (as needed) orders for Lorazepam. The form requested the prescriber evaluate the current orders and consider discontinuing one of the orders. The form lacked the documentation to show the provider agreed, disagreed and/or other and had no documented comments. A Pharmacy Recommendation form, dated 11/2/2023, indicated the residents orders had a duplication in therapy with 2 orders for Lorazepam at hs (bed time). Again, the form requested the prescriber evaluate the current orders and consider discontinuing one of the orders. The Pharmacy Recommendation form had the following hand written note "faxed to pharm 1-23-24" on the top of the form, and the Prescribers Response and comments indicated the presciber had agreed with the recommendation, with a signed date of 1/22/2024. A Pharmacy Recommendation form, dated 3/3/2024, indicated Resident 4 had an order for Quetiapine (an antipsychotic) less than 50 mg daily. The recommendation requested the prescriber evaluate the current dose of Quetiapine and suggested it be discontinued. The form requested the prescriber provide a rationale as well as a risks/benefit statement if the medication therapy was to be continued. The form lacked the documentation to show the provider had responsed to the form and had agreed, disagreed and/or provided any other documented comments. During an interview, on 6/13/2024 at 3:19 P.M., the Director of Nursing indicated the pharmacy recommendation should have been followed up on timely.			

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	On 6/13/2024 at 10:15 A.M., the Director of Nursing provided the policy titled,"Consultant Pharmacist Reports", with a revision date of 11/2018, and indicated the policy was the one currently used by the facility. The policy indicated "...B. A pharmacist reviews the medication regimen of each resident routinely ad required by state or federal regulations...3) The findings are phoned, faxed, or e-mailed to the Director of Nursing or designee and are documented and stored with the other Consultant Pharmacy recommendations in an easily retrievable format...E. recommendations are acted upon and documented by the facility personnel and/or the prescriber. 1.) Prescriber accepts and acts upon suggestion or rejects and provides and explanation for disagreeing...."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.			

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	Based on observation, record review and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 3 of 7 residents. (Residents 8 ,7,& 9) Finding includes: 1. A record review for Resident 8 was completed on 6/12/2024 at 2:41 P.M. Diagnoses included, but were not limited to,vascular dementia, depression, and stage 3 kidney disease. The emergency information file did not have a hospital preference listed on the provided face sheet for Resident 8. 2. A record review for Resident 7 was completed on 6/12/2024 at 2:04 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, congestive heart failure, and malignant neoplasm of bronchus or lung. The emergency information file did not have a hospital preference listed on the provided face sheet for Resident 7. 3. A record review for Resident 9 was completed on 6/12/2024 at 1:26 P.M. Diagnoses included, but were not limited to, epilepsy, generalized anxiety, depression, and schizoaffective disorder. The emergency information file did not have a hospital preference listed on the provided face sheet for Resident 9. During an interview, on 6/13/2024 at 10:54 A.M., the Director of Nursing indicated a face sheet with the necessary information and the code status should be in the emergency information	R 0356	3 residents were affected by this deficient practice. All residents had the potential to be affected. An audit of the emergency binder was completed on 6/23/24. All missing information was obtained and added to each resident's face sheet. An audit of the emergency binders will be completed each month between the 1st and the 5th using a resident roster tool. All missing/incorrect information will be added/updated. This will be done indefinitely and review monthly at QA.	07/23/2024

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	file. She indicated the resident's hospital preference should be listed on their face sheet. A policy was provided, on 6/13/2024 at 2:50 P.M., by the Director of Nursing. The policy titled, "Responding to Medical Emergencies Expectations Training", indicated, " ...d. Have information ready for paramedics including: i. Admission Data Sheet [face sheet] ii. Current Medication Record iii. Current physician's orders iv. Code Status form ...."			
R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on record review and interview, the facility failed to complete a comprehensive plan of care within 30 days for 1 of 1 resident reviewed for mental illness. (Resident 9) Finding includes: A record review for Resident 9 was completed on 6/12/2024 at 1:26 P.M. Diagnoses included, but were not limited to, epilepsy, generalized anxiety, depression, and schizoaffective disorder. Resident 9 was admitted to the facility on 8/30/2023. The current physician's orders included orders for the following medications: - buspirone 10 milligrams twice daily for anxiety -diazepam 5milligrams three times a day for generalized anxiety -duloxetine 60 milligrams twice daily for depression	R 0382	One resident was affected by this deficient practice. All residents with major mental illness had the potential to be affected. The facility obtained a signed contract with Rounding Providers to provide psychiatric services for our residents. An audit of all residents with antipsychotic medications order and/or psychiatric diagnosis will be completed 7/23/24. All affected residents were offered psychiatric services with Rounding Providers who will provide care going forward. A nursing staff in-service will be completed by 7/23/24. All residents will be screened pre-admission and evaluated to determine the need for psychiatric services. Upon admission these qualifying residents will be set up	07/23/2024

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	-mirtazapine 7.5 milligrams at bedtime -olanzapine 10 milligrams at bedtime for schizophrenia -precisedose 1 milligram/milliliter 1 milliliter intramuscularly as needed for insomnia A comprehensive care plan related to Resident 9's mental health diagnosis was not available and there was no indication the resident had been seen by a mental health professional to help develop a plan of care related to the resident's major mental illness diagnosis. On 6/13/2024 at 2:50 P.M., the Director of Nursing indicated no policies were available regarding mental health care plans and services.		with Rounding Providers to start/continue all psychiatric related care so a comprehensive care plan can be developed. All residents with a MMI care plans will be monitored and checked for accuracy weekly x 4 weeks, bi-weekly x 6, then monthly x 2.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure an infection control program was maintained related to not having an infection control log to monitor infections within the facility. Finding includes:	R 0407	No residents were affected by this deficient practice. All residents had the potential to be affected by this deficient practice. An audit of the infection control binder will be completed by 7/23/24. All nurses will be	07/23/2024

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	A review of the facility infection control binder was completed on 6/13/2024 at 10:50 A.M. There were monthly Illness Tracking Forms (GI Illness/Norovirus/Other Illness) from January to May 2024 in the binder. The January Illness Tracking Form had the following: -4 residents listed with an UTI (urinary tract infection) and ABT (antibiotic) x 7 days. No other clinical information was documented on the form regarding any lab collection date, lab results, treatment date and/or infection resolved informaiton. The February Illness Tracking Form had the following: -1 resident with a tooth infection with no signs/symptoms or resolved date documented. -3 residents listed with an UTI with no signs/symptoms, labs completed or resolved date documented. -1 resident with conjunctivitis with no signs/symptoms,or resolved date documented. - The March Illness Tracking Form had the following: - 10 residents listed with a UTI, 3 with the antibiotic listed and 6 without the name of the antibiotic listed, no signs/symptoms of the infection, labs completed or a resolved date for the infection documented. The April Illness Tracking Form had the following: -8 residents with an UTI's listed with no treatment documented, no signs/symptoms of the infection, labs completed, lab results and/or resolved dates documented for the infections.. -2 residents with URI (upper respiratory infection) with no signs/symptoms, no labs completed, no		educated on how to correctly document on the clinical forms by 7/23/24. Ad audit of the infection control binder will be completed twice weekly for 1 month, then once weekly for 1 month, then monthly for 4 months. Audits will include education and disciplinary action as needed.	

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	lab results and/or resolved dates documented. The May Illness Tracking Form had the following: -5 residents listed with an UTI's with no signs/symptoms of the infection, labs completed, lab results and/or resolved dates documented. - 3 residents listed with cellulitis (bacterial skin infection) with no signs/symptoms of the infection , labs completed, lab results or resolved dates documented. During an interview, on 6/13/2024 at 1:29 P.M., the Director of Nursing indicated she did not include all the information for the infections on the forms and should have. On 6/13/2024 at 1:30 P.M. a policy was requested for the Infection Control Program, but one was not provided prior to the survey exit.			