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	08/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00387655 and IN00388494. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00375944, IN00378128, IN00379613, and IN00380591 completed on June 16, 2022. Complaint IN00387655 - Substantiated. State deficiencies related to the allegations are cited at R0091. Complaint IN00388494 - Substantiated. State deficiencies related to the allegations are cited at R0091. Complaint IN00375944 - Corrected. Complaint IN00378128 - Corrected. Complaint IN00379613 - Corrected. Complaint IN00380591 - Corrected. Survey date: August 22, 2022 Facility number: 010890 Residential Census: 62 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/26/22.	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. On 09/08/2022 the Administrator, with oversight from the Regional Nurse Consultant will ensure all corrective action in the following POC has been completed.	
R 0091	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management -			

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

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Bldg. 00	Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to implement the Fall Management policy related to care of a resident post fall, for 1 of 3 residents reviewed for implementation of the Fall Management policy. (Resident C) Finding includes: The closed record for Resident C was reviewed on 8/22/22 at 1:18 p.m. Diagnoses included, but were not limited to, dementia. The Level of Care assessment, dated 4/29/22, indicated the resident required stand by assist for transfers and 1 person assist for toileting. The resident was also identified as having memory impairment. The Fall Risk assessment, dated 7/13/22, indicated the resident was at risk for falls. Nurses' Notes, dated 7/25/22 at 2:27 p.m., indicated the resident was complaining of left hip pain. The area was noted with swelling and was warm to touch. The Nurse Practitioner (NP) was notified and orders were received for a 2 view x-ray of the left hip. The resident and family were updated.	R 0091	**What correction action will be accomplished for those residents found to have been affected by the deficient practice?** All caregivers, QMA's, and licensed nurses have been educated of the following policy and procedures: Should a resident fall, caregivers are instructed to summon immediate assistance from the licensed nurse on duty. The licensed nurse will then immediately conduct a physical assessment of the resident and determine if emergency medical services are needed and if so, 911 is called. If emergency medical services are not needed as determined by the licensed nurse's assessment, the resident is assisted off the floor. Caregivers do not move the resident, except to protect against further injury, as in the case of a dangerous environment. The licensed nurse then notifies the	09/08/2022

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	The next entry in the Nurses' Notes was on 7/27/22 at 4:29 p.m. The notation was a late entry for 7/26/22 at 2:00 p.m., which indicated the resident's granddaughter came to the facility requesting medical records for the resident. The resident had a hip fracture that required surgery. The resident was sent to the hospital on 7/25/22 for evaluation and treatment of the hip pain. An investigation was started at that time. The Resident Incident Report, dated 7/26/22 at 1:30 p.m., indicated the resident's family came to the facility and reported the resident was hospitalized with a left hip fracture. On 7/25/22, per family request, the resident was sent to the hospital for hip x-rays. The writer had already obtained an order for x-rays prior to family arriving at the facility related to the resident's complaint of pain. An investigation was initiated and the incident was reported to the State Agency. Interview with the Resident Care Director (RCD) on 8/22/22 at 3:02 p.m., indicated, on 7/25/22, she was told the resident was having complaints of pain to her hip. When she assessed the area, it was warm to touch and the resident screamed out in pain. She indicated she had not been told the resident had fallen over the weekend or had any other incident. The RCD indicated she notified the NP and orders were received for x-rays. When the resident's family arrived to the facility, they wanted her sent to the hospital for evaluation. The RCD indicated on 7/26/22, the resident's granddaughter informed the facility the resident had a fractured hip and an investigation was started. She indicated the family had a video camera in the resident's room and footage was reviewed. On 7/24/22 at 4:16 a.m., the resident was observed on the floor. CNA 1 entered the resident's room and put her back to bed. The RCD		resident's physician and responsible party. Any significant changes in resident's status is reported to the Resident Care Director. The licensed nurse places the resident on alert charting for at least 48 hour after any fall. The Resident Care Director ensures the service plan is updated with fall interventions in place. ="" b="">"> All residents of the community have the potential to be affected. See corrective actions above being taken. **What measures will be put into place or what systemic changes will the community make to ensure the deficient practice does not recur** The Resident Care Director or designee will educate all community staff members and agency personnel regarding Fall Response Policies & Procedures. Monthly, all staff in-service's will include the "When to Call" Protocol procedures and the "Fall Response Procedures". **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Leadership team or designee will round on the midnight shift randomly once per week for 3	

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	indicated the CNA did not tell anyone or call her to let her know the resident had been found on the floor. The RCD also indicated, during further video review for 7/24/22, 3 Agency staff members were viewed in the resident's room providing incontinence care. She indicated the way the resident responded to pain on 7/25/22, she would have assumed the resident would have had the same response during incontinence care. A statement from CNA 1 was obtained on 7/26/22 at approximately 3:30 p.m., the CNA indicated he was aware of the policy to report an incident or concerns. He described the policy in detail and upon his own admission, he indicated he did not follow the appropriate process. He was asked if he had experienced any situations that may warrant him to follow the protocol. He said that he had been warned that he was going to be called in for questioning related to Resident C's fall. He indicated the resident fell to the floor and he admitted to picking her up and putting her back to bed without telling anyone. He did not think anything was abnormal because she was moaning at the time and she "always moaned" when care was being provided. The CNA admitted he made a bad judgement call. The RCD indicated the CNA was suspended pending investigation and then terminated. The 3 Agency staff members were added to the Do Not Return (DNR) list and were no longer allowed to cover shifts at the facility. The Fall Response procedure, dated 9/1/21, was provided by the RCD on 8/22/22 at 3:15 p.m. The procedure indicated, "Should a resident fall, caregivers are instructed to summon immediate assistance from the Resident Care Director or Nurse/QMA on duty. Caregivers do not move the resident, except to protect against further injury, as in the case of a dangerous environment."		months to ensure resident safety, as well as ensure Fall Response Procedures and When to Call protocol procedures are being followed. Monthly, the Regional Nurse Consultant reviews and audits all incident reports to ensure compliance as the ongoing QA system. **By what date the systemic changes will be completed:** All corrective actions will be completed by 09/08/2022	

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	This State Residential finding relates to Complaints IN00387655 and IN00388494.			