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	03/29/2023

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 IN00403196 and IN 00404476. Complaint IN00403196 - State deficiencies related to the allegations are cited at R0052 and R0090. Complaint IN00404476 - State deficiencies related to the allegations are cited at R0036 and R0241. Survey date: March 29, 2023 Facility number: 010890 Residential Census: 70 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/3/23.	R 0000		
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 commence a new form of treatment. Based on record review and interview, the facility failed to notify a resident's family about a change in condition related to a new wound requiring treatment for 1 of 3 residents reviewed for wounds. (Resident C)	R 0036	Staff educated and in-serviced on documentation and notification to family, resident, and MD when a change in status occurs. Staff to also notify the family of all new	05/30/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shirly Keller	Executive Director	04/28/2023

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	Finding includes: Resident C's record was reviewed on 3/29/23 at 9:10 a.m. The resident was admitted to the facility on 1/30/23 and discharged on 3/2/23. Diagnoses included, but were not limited to, amnesia and osteoarthritis. The resident resided on the locked memory care unit. A Progress Note, dated 2/26/23, indicated the resident had bleeding noted on his left lower leg. The area was cleaned and treatment applied. There was no documentation what type of treatment was applied or that family had been notified. A Progress Note, dated 2/27/23, indicated the area on left lower leg appeared as if skin had sloughed off, the area was 10 cm (centimeters) x 5 cm. The area was cleaned and a new dressing applied, the Nurse Practitioner was notified. There was no documentation the family had been notified. Interview with the Director of Nursing (DON), on 3/29/23 at 11:50 a.m., indicated the family had not been notified of the new wound. The DON was not aware of that until after the resident was discharged and the family had called the facility. The nurse involved had been reeducated about family notification. The current policy, "Change in Resident Status," indicated, "...3. a. The facility must immediately consult the resident's Physician and the resident's legal representative with the facility has noticed:...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...."		orders received from MD. Director of Nursing, Resident Care Coordinator, and Memory Care Director will read/audit all progress notes daily ensuring that all orders are carried out and all notifications are completed indefinitely.	

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	This state residential finding relates to Complaint IN00404476.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from sexual abuse by another resident for 1 of 3 residents reviewed for abuse. (Resident D) Finding includes: An Incident Report, dated 3/2/23, indicated at approximately 4:45 p.m., Resident D was found in Resident C's room. Both residents had their pants down, seated on the bed, and Resident C had his fingers in Resident D's vagina. The residents were separated immediately and assessed for injury. Resident C was placed on one on one care until family arrived. Resident D's record was reviewed on 3/29/23 at 8:50 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia. The resident resided on the locked memory care unit. Resident C's record was reviewed on 3/29/23 at 9:10 a.m. Diagnoses included, but were not limited to, amnesia and osteoarthritis. The resident resided on the locked memory care unit. The Incident Activity/ Location log was initiated	R 0052	All residents could be affected by the deficient practice. House wide audit of charting for the past 90 days (approximately 3 months) will be completed to ensure no other state reportable issues occurred. All residents affected by the deficient practice were assessed and addressed properly according to protocol and MD orders at time of incident. All staff to be trained in sexual expression, abuse, neglect, and exploitation. Nursing notes will be reviewed daily to ensure no state reportable issues occurred. Executive Director, Director of Nursing and Memory Care Director will meet daily to discuss any issues, concerns, or findings, ensuring that all occurrences are reported. Huddles/Meetings will be done with staff at shift change to discuss updates and concerns focusing on resident behaviors with follow up/and or state	05/30/2023

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	on 3/1/23 for Resident C. The log indicated he was on 30 minute checks. He was observed in his bedroom alone on 3/2/23 at 4:30 p.m. Interview with the Director of Nursing on 3/29/23 at 11:50 a.m., indicated Resident C had previous episodes of being sexually inappropriate prior to the event on 3/2/23. On 2/28/23, the resident had been overheard making a sexual proposition to a female resident. The nurse intervened immediately. On 3/1/23, the resident had been found by staff unclothed on his bed with a female resident, also unclothed, standing near his bed. The resident was placed on 15 minute checks. On 3/29/23 at 1:10 p.m., Resident D was observed seated in the dining room with two other residents. She was alert, very confused and unable to answer questions appropriately. Interview with the Memory Care Director, on 3/29/23 at 12:40 p.m., indicated the Resident C had been placed on 15 minute checks after the event on 3/1/23. Interview with Caregiver 1 on 3/29/23 at 1:11 p.m., indicated staff was instructed to keep his door closed and keep female residents out of his room. This state residential tag relates to Complaint IN00403196.		reporting when needed. Management meetings will be documented and tracked for 6 months by the Executive Director or designee.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual			

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	occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports			

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	available for inspection to any member of the public upon request Based on record review and interview, the facility failed to report an unusual occurrence to the State Agency related to two residents on the memory care unit found unclothed in a room alone. (Residents C and B) Finding includes: Resident C's record was reviewed on 3/29/23 at 9:10 a.m. The resident was admitted to the facility on 1/30/23 and discharged on 3/2/23. Diagnoses included, but were not limited to, amnesia and osteoarthritis. The resident resided on the locked memory care unit. Resident B's record was reviewed on 3/29/23 at 1:47 p.m. Diagnoses included, but were not limited to, dementia with behaviors. She resided on the locked memory care unit. A written witness statement, dated 3/1/23, indicated CNA 2 had entered Resident C's room on 3/1/23 at 7:10 a.m. The resident was lying on the bed completely naked, Resident B was was completely naked walking around the side of the bed. The CNA dressed Resident B, exited the room and notified the QMA on duty. Resident C was placed on 30 minute checks following the incident. Interview with the Director of Nursing on 3/29/23 at 11:50 a.m., indicated the resident had been found in his room unclothed with a female resident, also unclothed, on 3/1/23. Interview with the Executive Director on 3/29/23 at	R 0090	The management team met and reviewed scenarios that would be considered an unusual occurrence. The management team reviewed and educated on the state regulations and reporting manual. Corporate Nursing Team will review all state reportable incidents as they occur indefinitely. All risk management/incident reports reviewed to ensure all incidents were reported appropriately. All residents could be affected by the deficient practice. Management will have clinical morning meeting to discuss concerns/behaviors. Internal occurrence reports will be reviewed at these meetings to determine if the occurrence will be reported to IDOH. the Executive Director or designee will report all unusual occurrences to the IDOH within the allotted twenty-four-hour period. Meeting will be documented and tracked for 6 months by the Executive Director and Corporate Clinical Team.	05/30/2023

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	11:55 a.m., indicated she did not think the incident needed to be reported, and did not report to the State Agency. The current policy, "Resident Abuse and Neglect", indicated, "...B. 1. Staff members, as mandated reporters, have a duty to report all suspected abuse and neglect...2. Promptly notify State agencies as required by law...." The state residential tag relates to Complaint IN00403196.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure a resident received treatment for wounds related to not obtaining a Physician's Order for wound care and providing incorrect treatment after a Physician's Order was received for 1 of 3 residents reviewed for wound care. (Resident C) Finding includes: Resident C's record was reviewed on 3/29/23 at 9:10 a.m. The resident was admitted to the facility on 1/30/23 and discharged on 3/2/23. Diagnoses included, but were not limited to, amnesia and osteoarthritis. The resident resided on the locked memory care unit.	R 0241	All nursing staff have been educated in reporting changes in condition including skin issues. Staff were also educated on the procedure for getting new orders and carrying the orders out, including family notifications and documentation. All residents could be affected by the deficient practice. Facility wide skin sweep to be completed, assessing all residents for any wounds or skin issues. The Nursing management team will ensure all skin issues are documented correctly, MD and	05/30/2023

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	A Progress Note, dated 1/30/23, indicated the resident had a wound on his left lower leg measuring 3 centimeters (cm) x 1.5 cm and would need wound care to address. There was no Physician's Order for wound treatment. A Progress Note, dated 2/3/23, indicated a referral had been sent to home health agency for wound care. The request was denied due to insurance issues on 2/7/23. On 2/7/23 a referral was sent to another home health agency for wound care. The referral was also denied. A Progress Note, dated 2/5/23, indicated wounds on the resident's lower leg remained. The area was washed with saline, patted dry, triple antibiotic ointment and sterile gauze were applied. A Progress Note, dated 2/9/23, indicated the MD had looked at the resident's leg and provided an order for bacitracin (antibiotic ointment) and an ABD (dry dressing) to be applied daily. A Physician's Order, dated 2/9/23, indicated to apply A&D ointment (a skin protectant) and ABD covering daily. The Medication Administration Record (MAR) indicated A&D ointment (a skin protectant) had been applied on 2/10, 2/11, 2/12, 2/13, 2/14 and 2/15/23 to the wound. Bacitracin was not on the MAR. A Progress Note, dated 2/10/23, indicated the wound was washed with saline, and bacitracin and ABD were applied. A Progress Note, dated 2/13/23, indicated the		families will be notified, all orders received will be sent to pharmacy for uploading into the EMAR/TAR. Director of Nursing, Resident Care Coordinator, and Memory Care Director will read nursing notes daily and complete an audit form ensuring that all new orders are carried out correctly. Audits to continue for six months.	

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	wound was washed with saline, antibiotic ointment was applied to the wound, and A&D ointment was applied to the surrounding skin, the wound was covered with ABD and compression stockings had been applied. A Progress Note, dated 2/15/23, indicated the wound had healed. A Progress Note, dated 2/26/23, indicated the resident had bleeding noted on his left lower leg. The area was cleaned and treatment applied. There was no documentation what type of treatment was applied. A Progress Note, dated 2/27/23, indicated the area on left lower leg appeared as if skin had sloughed off. The area was 10 cm x 5 cm. It was cleaned and new dressing applied, the Nurse Practitioner (NP)was notified. There was no Physician's Order documented for treatment of the new wound. Progress Notes, dated 2/28, 3/1 and 3/2/23, indicated the dressing was dry and intact. There was no further documentation in Progress Notes or the MAR that wound care had been provided to the area. The resident was discharged on 3/2/23. Interview with the Director of Nursing (DON) on 3/29/23 at 11:50 a.m., indicated there was supposed to be a standing order from the NP for wound care, but it had not been entered on admission. The standing order was for A&D ointment and dry dressing daily. The order given on 2/9/23 was for A&D ointment and ABD daily, the nurses should not have been applying antibiotic ointment. She indicated the NP had			

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	been notified on 2/27/23 of the new wound and had given a verbal order to resume previous treatment. That order had also not been entered, and there was no documentation of wound care. This state residential finding relates to Complaint IN 00404476.			