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	06/20/2019

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BRENTWOOD AT LAPORTE	2002 ANDREW AVE LA PORTE, IN 46350

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: June 19 & 20, 2019 Facility number: 010890 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/21/19.	R 0000	This Plan of Correction is submitted as required by the Indiana State Department of Health. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing			

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

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	personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure an annual inservice was completed related to Resident Rights for 2 of 5 employee files reviewed. (LPN 1 and QMA 2) Findings include: 1. The employee file for LPN 1 was reviewed on 6/20/19 at 10:00 a.m. LPN 1 was hired on 2/3/16. The LPN did not receive an annual inservice related to Resident Rights for the year of 2018. 2. The employee file for QMA 2 was reviewed on 6/20/19 at 10:05 a.m. QMA 2 was hired on 5/12/17. The QMA did not receive an annual inservice related to Resident Rights for the year of 2018. Interview with the Business Office Manager on 6/20/19 at 11:00 a.m., indicated there was no documentation available related to the employees	R 0120	The identified employees were provided Resident Rights inservices. All residents could have been affected by the alleged deficient practice. Employee files were audited for necessary inservice training on June 25th and 26th. Relias Learning course assignments were provided to all staff and will be monitored by the Executive Director or designee for completion each month for four months. Executive Director/designee will provide the completion records	07/12/2019

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	receiving an annual inservice related to Resident Rights.		through the QA committee monthly for three months and quarterly thereafter. Any employee found in noncompliance will be removed from the schedule until compliance is met.	
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 observation, record review, and interview, the facility failed to ensure Physician's orders were followed as written related to blood pressure parameters, sliding scale insulin administration, and giving medications as ordered for 3 of 7 sampled residents. (Residents 2,4, and 5) Findings include: 1. The record for Resident 2 was reviewed on 6/19/19 at 11:41 a.m. The resident was admitted to the facility on 3/31/19. Diagnoses included, but were not limited to, atrial fibrillation, hypothyroid, hypertension, congestive heart failure, diabetes, chronic obstructive pulmonary disease, and depression. A Physician's Order, dated 4/1/19, indicated the resident was to receive Lisinopril (a blood pressure medication) 5 milligrams (mg) daily. The medication was to be held if the resident's systolic (top number) blood pressure was less than 110.	R 0241	The orders were clarified on the identified Residents. Nursing staff were in-serviced to manage medications as prescribed by the physician. The specific employees were given corrective action and educated on the five rights of medication administration. All residents could have been affected by alleged deficient practice. A chart audits were conducted on all residents receiving insulin and Lisinopril. Each chart had a clarification order if needed and staff were instructed/in-serviced on following physician orders. All medicines will be provided as physician ordered.	07/12/2019

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	The May 2019 Medication Administration Record (MAR) indicated the following: - 5/2/19 blood pressure 118/66, medication was held - 5/4/19 blood pressure 108/50, medication was given - 5/14/19 blood pressure 106/50, medication was given The June 2019 MAR indicated the following: - 6/16/19 blood pressure 90/56, medication was given A Physician's Order, dated 4/1/19, indicated the resident was to receive Novolog insulin four times a day based on the following sliding scale dosing: 151-200=1 unit 201-250=2 units 251-300=3 units 301-350=4 units 351-400=5 units Greater than 400=6 units and call Physician. The May 2019 MAR, indicated the following: - 5/15/19 PM blood sugar 246, 3 units of insulin was given rather than 2 - 5/16/19 Noon blood sugar 171, 3 units of insulin was given rather than 1 - 5/19/19 Noon blood sugar 239, 1 unit of insulin was given rather than 2 - 5/26/19 no blood sugar results were documented at bed time (HS) Interview with the Nurse Consultant on 6/20/19 at 11:30 a.m., indicated the resident's blood pressure		The Director of Wellness/Designee will complete audits three times per week for one month and then weekly for three months, (to and then quarterly thereafter to ensure that all medicines are provided as physician ordered.) The audit will be shared through the monthly QA process by the Director of Wellness/designee. Any clarifications or corrections will be immediately address by the Director of Wellness/designee.	

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	parameters should have been followed and the sliding scale insulin coverage should have been given as ordered. .2. On 6/19/19 at 2:10 p.m., QMA 1 was observed preparing eye drops for Resident 4. The QMA entered the resident's room. She had washed her hands with soap and water and donned clean gloves to both hands. She instructed the resident to lean her head back and she administered 1 drop into each eye. The record for Resident 4 was reviewed on 6/19/19 at 12:45 p.m. The resident was admitted to the facility on 3/22/16. Diagnoses included, but were not limited to, brain cancer, dementia, seizures, and high blood pressure. A Service Plan, dated 3/26/19, indicated the resident was not alert and oriented to person, place, or time. Physician's Orders, dated 4/6/19, indicated Lubricating Eye Drops 0.4-0.3% solution, administer 2 drops in each eye three times a day. Interview with QMA 1 on 6/19/19 at 2:25 p.m., indicated she had only administered 1 drop into each eye. 3. The record for Resident 5 was reviewed on 6/19/19 at 1:30 p.m. Diagnoses included, but were not limited to, dementia, chronic kidney disease, osteoarthritis, diverticulum of the esophagus, and coronary artery disease. Physician's Orders, dated 6/13/19, indicated Prednisone (a steroid) 1 milligram (mg) daily. Another Physician's Order, dated 6/13/19, indicated Prednisone 5 mg daily. The Medication Administration Record (MAR),			

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	dated 6/2019, indicated the resident had been receiving Prednisone 5 mg daily and Prednisone 1 mg, 3 tablets daily give with the 5 mg for a total of 8 mg. The 8 mg of Prednisone had been signed out as being administered 6/13-6/19/19. The medication punch card for the Prednisone was observed at that time. The label on the medication indicated, Prednisone 1 mg daily. A handwritten "iii" was on the label. Interview with QMA 1 on 6/19/19 at 2:25 p.m., indicated she had administered 8 mg of Prednisone in the morning to the resident. Interview with the Director of Wellness on 6/20/19 at 8:45 a.m., indicated the Physician was called yesterday, the order was clarified for the resident to receive a total of 6 mg of Prednisone daily and not 8 mg.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to lack of documentation to indicate the use of an antipsychotic medication and interventions tried first before the administration of an anti-anxiety medication for 1 of 7 sampled residents. (Resident	R 0349	The Seroquel order was clarified and a corresponding diagnosis was added. The PRN Lorazepam order was given to utilize non-pharm logic interventions prior to usage of PRN Lorazepam	07/12/2019

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	4) Finding includes: The record for Resident 4 was reviewed on 6/19/19 at 12:45 p.m. The resident was admitted to the facility on 3/22/16. Diagnoses included, but were not limited to, brain cancer, dementia, seizures, and high blood pressure. A Service Plan, dated 3/26/19, indicated the resident was not alert and oriented to person, place, or time. Physician's Orders, dated 2/8/19, indicated Seroquel (an antipsychotic medication) 25 milligrams (mg) at night time. Physician's Orders, dated 4/12/18, indicated Lorazepam (an anti-anxiety medication) 0.25 milliliter (ml) (0.5 mg) every 2 hours prn (as needed) for anxiety/dyspnea. There was no appropriate diagnosis for the use of the Seroquel in the clinical record. The Medication Administration Record (MAR) indicated the resident was administered the prn Lorazepam on 3/30/19 at 12:41 p.m., 5/2 at 4:03 p.m., 5/20 at 2:49 a.m., 5/22 at 12:59 a.m., and on 6/1/19 at 12:38 a.m., for anxiety/dyspnea. There was no documentation in the resident's clinical record of interventions tried first before the administration of the prn anti-anxiety medication on the above mentioned dates. Interview with the Nurse Consultant on 6/19/19 at 3:20 p.m., indicated the diagnosis for the Seroquel was dementia and there was no documentation of		All residents with nurse medication assistance could have been affected by alleged deficient practice. Chart audits were completed by the Director of Wellness and Nurse Consultant. Any discrepancy order by medication and/or diagnosis were corrected. The Director of Wellness/designee will conduct chart audits three times weekly and then weekly for three months (and quarterly with PCA pharmacy thereafter to ensure proper diagnosis for medications prescribed). Findings will be presented by the Director of Wellness/designee through the monthly QA meeting. Any concerns will be immediately addressed by the Director of Wellness/designee.	

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	any interventions tried first before administering the Lorazepam.			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure an annual tuberculin skin test was completed for 1 of 7 sampled residents. (Resident 4) Finding includes: 1. The record for Resident 4 was reviewed on 6/19/19 at 12:45 p.m. The resident was admitted to the facility on 3/22/16. Diagnoses included, but were not limited to, brain cancer, dementia, seizures, and high blood pressure. There was no annual tuberculin skin test available for review. Interview with the Director of Wellness on 6/19/18 at 1:30 p.m., indicated the tuberculin test was not completed.	R 0409	The identified Resident was provided a tuberculin skin test. All residents could have been affected by the alleged deficient practice. All Resident charts were audited for compliance of Tuberculin skin testing. Any concerns were immediately addressed. The Medication Administration Record will be utilized as the trigger for initial and annual Tuberculin skin testing audit. The Director of Wellness/designee will monitor 30% of MAR s for compliance quarterly for two quarters then 10% quarterly for two quarters then 5% thereafter. Findings will be presented by the Director of Wellness/designee through the monthly QA meeting. Any concerns will be immediately addressed by the	07/12/2019

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