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	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT HOBART	1420 ST MARYS CIRCLE HOBART, IN 46342

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00427514 and IN00430896. Complaint IN00427514 - State deficiency related to the allegations is cited at R0349. Complaint IN00430896 - State deficiencies related to the allegations are cited at R0036 and R0349. Survey date: April 3 and 4, 2024 Facility number: 002627 Residential Census: 119 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/9/24.	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 ensure a resident's responsible party was notified of a change in condition, for 1 of 1 resident reviewed for change in condition. (Resident B)	R 0036	All nursing staff in-serviced on timely notification to responsible party when new orders and/or change of condition occurs.	05/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sandra Williams	Administrator	05/11/2024

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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	Finding includes: Resident B's record was reviewed on 4/3/24 at 9:22 a.m. Diagnoses included, but were not limited to, dementia and major depressive disorder. A Service Plan, dated 3/30/24, indicated the resident had memory loss. A Progress Note, dated 12/24/23 at 5:31 a.m., indicated a new order was received for Keflex (an antibiotic) 500 milligrams twice daily for 10 days for urinary tract infection (UTI). There was no documentation related to notification of the resident's responsible party. During an interview, on 4/4/24 at 12:50 p.m., the Executive Director indicated the resident's responsible party should have been notified of the change of condition and start of antibiotic therapy. This citation relates to Complaint IN00430896.		Director of nursing and administrator to review all new orders received daily for 30 days then every other day for 30days then weekly indefinitely to ensure all responsible parties are notified. Director of nursing and administrator to review 24hr progress notes daily indefinitely to ensure all responsible parties are notified of new medication orders and any changes in condition. Service plan to be reviewed weekly per Director of nursing to ensure the care matches the need of the resident. Services plans to be audited weekly for 90days then monthly indefinitely.	
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 observation, record review, and interview, the facility failed to ensure records were	R 0349	All nursing staff in-serviced on post unwitnessed fall policy with	05/31/2024

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	accurately documented and readily accessible, related to monitoring bruises and skin conditions and fall follow-ups, for 3 of 6 residents reviewed. (Residents B, E, and F) Findings include: 1. On 4/3/24 at 11:37 a.m., Resident B was observed walking in the hallway wearing day clothes and tennis shoes. There was a small discoloration noted below his right eye. On 4/4/24 at 11:43 a.m., Resident B was observed walking in the hallway. There was a small discoloration noted below his right eye. Resident B's record was reviewed on 4/3/24 at 9:22 a.m. Diagnoses included, but were not limited to, dementia and major depressive disorder. A Service Plan, dated 3/30/24, indicated the resident had memory loss. An Incident Note, dated 3/18/24 at 12:29 a.m., indicated the resident was involved in an altercation with another resident. He had entered another resident's room and would not leave, prompting a fight resulting in the resident sustaining 2 small scratches to the left side of his neck. The area was cleansed and left open to air. A Progress Note, dated 3/19/24 at 2:28 p.m., indicated the resident had an area of discoloration noted to his right eye. A Progress Note, dated 3/20/24 at 2:17 a.m., indicated the resident had a purplish discoloration noted to the right peri-orbital area. A Skin/Wound Note, dated 3/20/24 at 10:28 p.m.,		neuro check to be completed x 72hours. Nursing staff in-serviced on skin policy and documentation. PLC skin assessment form in Point click care to be initiated upon discovery of skin issue with MD and responsible party notified immediately of skin issue. PLC skin assessment form to be completed weekly until skin issue is resolved. MD and responsible party notified of skin issue resolved. Service plan will be updated of skin issue and will be updated until resolved. Director of nursing and administrator to review all skin assessments weekly indefinitely. Staff to completed unwitnessed fall incident report and initiate neuro check assessment form in point click care. All shifts to complete neuro check assessment form x72hrs post fall. Post fall sheet to be completed with dates and signatures to ensure all vitals and assessment has been completed. Director of nursing and administrator to review all post falls and neuro check assessment through duration of 72hrs. Service plan to be reviewed per	

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	indicated the discoloration to the right eye area and right side of the neck remained. A Skin/Wound Note, dated 3/21/24 at 2:12 p.m., indicated the discoloration to the right eye area was fading and the right side of the neck remained. There were no other assessments or monitoring of the open area to the neck or discoloration to the right eye. During an interview, on 4/4/24 at 12:00 p.m., the Director of Nursing indicated the staff should have documented on the open areas and discoloration until they were both healed. A Policy titled, "Wound and Skin Care," and noted as current, indicated "...4. Whenever a caregiver observes an area of concern on a resident's skin (e.c. [for example], redness, wound, rash, swelling, bump, discoloration, etc.) and/or if the resident expresses any skin discomfort, the caregiver is to note it on the End of Shift Report and report it to the Resident Care Director. The Community nurse or designee is to meet with the resident and complete the Skin Integrity Monitoring Form. One form is completed for each separate area of concern. The Community Nurse or designee is to follow-up at least weekly until the skin issue is resolved..." 2. Resident E's record was reviewed on 4/3/24 at 12:57 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, chronic kidney disease, and high blood pressure. A Service Plan, dated 1/10/24, indicated the resident demonstrated inappropriate judgment		director of nursing and update per need of resident .	

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	and was at risk for falls related to balance problems, confusion, gait problems, and impaired mobility. An Incident Note, dated 2/10/24 at 2:27 a.m., indicated the resident was found on the floor in his room between his wheelchair and his dresser. The resident stated that he was going to the bathroom when he tripped over his floor mat and fell down, landing on his back. He said he hit his head on something, but did not know what. A Neurological Checklist, dated 2/10/24 at 2:36 a.m., was completed with an assessment and vital signs. A Neurological Checklist, dated 2/13/24 at 7:35 a.m., was completed with an assessment and vital signs. An Incident Note, dated 2/13/24 at 3:18 p.m., indicated the resident had a fall on the floor in front of his recliner, on his left side. Resident stated that he slid out of his bed. A Neurological Checklist, dated 2/13/24 at 7:35 a.m., was completed with an assessment and vital signs. An Incident Note, dated 2/20/24 at 11:06 p.m., indicated the resident was found on the floor in front of his recliner. There were no corresponding Neurological Checklists in the record. A Progress Note, dated 3/16/24 at 3:48 p.m., indicated the resident had returned from the hospital at 7:19 a.m. Vital signs were checked.			

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	There were no corresponding Neurological Checklists in the record related to the fall. During an interview on 4/4/24 at 10:42 a.m., the Executive Director indicated a Neurological Checklist should have been completed every shift every 8 hours for 72 hours per the policy. 3. Resident F's record was reviewed on 4/3/24 at 3:02 p.m. Diagnoses included, but were not limited to, high blood pressure and chronic kidney disease. A Service Plan, dated 12/13/23, indicated the resident was cognitively intact and was not ambulatory. A Progress Note, dated 2/19/24 at 2:21 p.m., indicated the resident was sent to the hospital in the morning due to a fall in the dining room. He returned with a right hip fracture and laceration to the right side of his head. A Progress Note, dated 2/19/24 at 5:33 p.m., indicated the writer was notified the resident was walking in the dining room when the med technician stated she saw him lose balance and fall. The med technician was unable to get to him in time. The resident hit the back of his head on the floor with bleeding noted. He was assessed and right leg shortening was observed. 911 was called to transfer the resident to the hospital for evaluation and treatment. Vital signs were unable to be obtained due to the resident being in pain. Neurological Checks, dated 2/19/24 at 2:39 p.m. and 2/20/24 at 8:30 a.m., were completed with an assessment and vital signs.			

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	During an interview on 4/4/24 at 10:09 a.m., the Executive Director indicated the resident had a fall around 8:00 a.m. and had gone to the hospital immediately afterwards due to the leg shortening. She had written her notes later that afternoon. She indicated the Neurological Checks were supposed to be completed every shift every 8 hours for 72 hours per the policy. A Policy titled, "Fall Prevention," and noted as current, indicated "...Post-Fall Management After a Resident Fall:...Reevaluate the resident and evaluate why the fall occurred and if there is a notable change in condition each shift for 72-hours." This citation relates to Complaints IN00427514 and IN00430896.			