

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2018
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NAME OF PROVIDER OR SUPPLIER BROOKDALE PORTAGE	STREET ADDRESS, CITY, STATE, ZIP COD 3444 SWANSON RD PORTAGE, IN 46368
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(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
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: March 15 & 16, 2018</p> <p>Facility number: 010889</p> <p>Residential Census: 35</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 3/19/18.</p>	R 0000	<p>The following is the Plan of Correction for Brookdale Portage regarding the Statement of Deficiencies dated March 16, 2018. 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, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</p>	
R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(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:</p> <p>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility</p>	R 0241	<p>·Resident #5: MD,</p>	03/19/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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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	<p>failed to ensure insulin was administered as ordered for 1 of 7 records reviewed. (Resident 5)</p> <p>Finding includes:</p> <p>The record for Resident 5 was reviewed on 3/15/18 at 11:17 a.m. Diagnoses included, but were not limited to, insulin dependent diabetes mellitus, dementia, and Alzheimer's disease.</p> <p>A Physician's order, dated 2/8/18, indicated the resident was to receive Novolog mix insulin 70/30, subcutaneously twice a day with meals. If the resident's blood sugar was below 110, the insulin was to be held.</p> <p>The February 2018 Medication Administration Record (MAR), indicated the resident's blood sugar was 101 at 5:00 p.m. on 2/19/18. The resident received his insulin at that time. On 2/27/18 at 9:00 a.m., the resident's blood sugar was 91. The resident received his insulin at that time. On 2/28/18 at 9:00 a.m., the resident's blood sugar was 108. The resident received his insulin at that time.</p> <p>The March 2018 MAR indicated the resident's blood sugar was 92 at 9:00 a.m. on 3/8/18. Again, the resident received his insulin at that time.</p> <p>Interview with the Health and Wellness Director, on 3/15/18 at 2:30 p.m., indicated the resident's insulin should have been held on the above dates.</p>		<p>Resident/Responsible party were notified of the medication errors related to insulin. The nurse who made the medication error received corrective action, as well as re-education related to Insulin Administration and the need to follow parameters.</p> <ul style="list-style-type: none"> -Other residents who require administration of insulin also have the potential to be affected, therefore audit of February and March Medication Administration Records (electronic MAR) was completed by the Health and Wellness Director (HWD)/Nurse Designee to determine if others were affected. -Licensed nursing staff was provided re-education on Insulin Administration and the need to follow parameters established by the physician order. This training was provided to Licensed Nurses by the HWD on 3/19/18. New hires will receive training from the HWD/Designee on Insulin Administration prior to independently administering insulin going forward. -The HWD, Executive Director (ED) or designee will monitor the MAR/electronic MAR 5x per week for the next 30 days to verify compliance, and at least weekly thereafter. <p>Additional corrective action will be at the discretion of the Executive Director, based on audit findings.</p> <ul style="list-style-type: none"> -Date of Compliance: 3/19/18 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-039

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