

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2013
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NAME OF PROVIDER OR SUPPLIER BLISS HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3008 SHAWNEE DR S BEDFORD, IN 47421
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R000000	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00123004.</p> <p>Complaint IN00123004 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: May 20, 21, and 22, 2013</p> <p>Facility number: 004011 Provider number: 004011 AIM number: N/A</p> <p>Survey team: Kimberly Perigo, RN-TC Cheryl Mabry, RN Diana McDonald, RN (5/20, 5/21, 2013)</p> <p>Census bed type: Residential: 40 Total: 40</p> <p>Census payor type: Other: 40 Total: 40</p> <p>Residential Sample: 13</p> <p>These state findings are cited in</p>	R000000		

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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 14 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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	<p>accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 23, 2013 by Randy Fry RN.</p>						

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R000215	<p>410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility.</p> <p>Based on observation, record review, and interview, the residential facility failed to ensure the required supervision had been provided for a resident identified to wander for 1 of 2 residents reviewed for elopement, in that a resident who exhibited wandering behavior had exited the facility without staff knowledge through an unsecured door. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical records were reviewed on 5/20/12 at 1:40 p.m.</p> <p>Resident #A's diagnosis included, but were not limited to memory problems associated with aging.</p> <p>The current Assessment and Negotiated Service Plan Summary dated 10/15/2012, indicated Resident #A independently ambulated (walked</p>	R000215	<p><u>ALC Sample Disclaimer Statement for Plans of Correction</u> - Use the following disclaimer statement unless your state-specific disclaimer statement is posted below: - Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Resident service plan was reviewed and updated to include interventions to minimize the risk for elopement. No other residents were found to be</p>	06/15/2013			

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	<p>without assistance). Resident #A required a service plan for orientation, behavior, and safety.</p> <p>The current Nursing Comprehensive Evaluation dated 2/7/13, indicated Resident #A was "memory impaired ... Ambulation I [independent] ..."</p> <p>A Mini Mental Status Examination dated 2/12/13, indicated a cognitive score of 11. The examination further indicated a cognitive score of 25 or less as suggestive of impairment and a score 10 or less being severely deficient.</p> <p>On 5/21/2013 at 2:25 p.m., LPN #1 was interviewed. During the interview LPN #1 indicated Resident #A's room was "closed off" due to pest control service. Resident #A was relocated from her room to a second unfamiliar room and during that time exhibited increased confusion and wandering behavior. Resident A often tried to get in other residents' rooms.</p> <p>On 5/22/2013 at 10:15 a.m., a pest control contract was provided by the Administrator (ADM). The contract indicated service dates of 3/22/2013 through 4/30/2013. The ADM verified Resident #A did not have access to her room from 3/22/2013 through</p>		<p>affected. Resident records were reviewed to identify those other residents who may have the potential to wander or experience exit seeking behavior. The Residence Director and Wellness Director have been re-educated to our policy and procedure regarding service level assessment completion. The Residence Director and/or Designee will be responsible for ensuring that service assessments are accurate and updated per our policy to assure that the care the resident requires is within the range of personal care and supervision provided by the residence. The Residence Director and /or Designee will be responsible for ensuring continued compliance with R217 410 IAC 16.2-5-2(b) Evaluation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put into place? The Residence Director and /or Designee will perform random weekly audits of resident service plans to ensure accuracy of the assessment and to ensure continued compliance with the above referenced regulation for a period of six months. Findings will be reviewed through the Bliss House QA process after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation</p>				

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	<p>4/30/2013.</p> <p>Continued review of Resident #A's clinical record Resident Services Notes indicated, "2/22/13 1430 [230 p.m.,] Resident ambulating well ... 2/25/13 1430 ... Resident ambulating well this shift ... [3/22/13 service contract began] ... 4/6/13 7pm ... found in another resident's bathroom ... 4/20/13 830p, found in several residents rooms-removed and showed her room numerous times. Totally messed up ... 4/21/13 9pm Found in kitchen fingering the silverware ... Resident found ... in library. 4/22/13 9pm Found in neighbors apartment ... 4/25/13 730p Resident found outside by dumpster p [after] another resident seen [sic] her enter the kitchen-used that route to leave the building. ... Will be monitored frequently and keep kitchen door locked. ..."</p> <p>Review of the Residential Facility's Incident Report dated 4/26/13, indicated " Staff (LPN) [LPN #1] was passing meds + PSA [aide] was getting resident ready for bed Resident came to PSA + and said he had seen a _____ [gender] go through the kitchen PSA check [sic] kitchen + found no one, she [LPN #1] then looked outside the kitchen door</p>		of the monitoring plan				

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	<p>+ _____ [Resident #A's name] was standing there..."</p> <p>Observation during initial kitchen tour on 5/20/2013 at 11:00 a.m., the kitchen exit door was observed to not alarm when opened.</p> <p>During interview on 5/21/13 at 2:05 p.m., the ADM verified the kitchen entrance door was unlocked on the evening of 4/25/13 and the kitchen exit door (to the outside) is the only facility door that is not alarmed, which if alarmed would notify staff the door had opened.</p> <p>Continued interview with LPN #1 on 5/21/13 at 2:25 PM, indicated Resident #A had walked through the kitchen entrance door; which had been unlocked and exited to the outside through the kitchen exit door. LPN #1 and the other staff member present in the facility that evening, had not observed Resident #A exiting the facility. The incident was reported by another resident who resided in the facility. Interventions of having locked the kitchen entrance door and to more closely monitor Resident #A had been implemented after she had wandered outside.</p> <p>On 5/21/13 at 1:13 p.m. the ADM</p>						

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	<p>provided a copy of the residential facility's Elopement or Missing Resident policy dated 01/01/2013. Review of the policy indicated, "Elopement Definition: When a cognitively impaired resident leaves the physical structure of the residence without staff knowledge and/or supervision. The resident lacks safety awareness and is unable to distinguish/identify his or her safety needs."</p>			