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 03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT PRESTWICK	182 S CR 550 E AVON, IN 46123

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R0000	This visit was for investigation of complaint number IN00084458. Complaint IN00084458: Substantiated, state residential finding related to the allegation is cited at R0217 Dates of survey: March 1 and 2, 2011 Facility number: 003902 Provider number: 003902 AIM number: NA Survey team: Vanda Phelps, R.N. Census bed type: Residential 121 Total 121 Census payor type: Other 121 Total 121 Sample: 3 This state residential finding is in accordance with 410 IAC 16.2-5. Quality review completed 3-8-11 Cathy Emswiller RN	R0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, record review and interviews, the facility failed to provide services to enhance resident safety and to meet the resident's demonstrated needs. This impacted 1 of 3 residents in a sample of 3 reviewed for elopement issues and resulted in an elopement in cold weather. (Resident T)	R0217	1.The corrective action to be completed will be for the facility to provide services to enhance resident safety and to meet the resident's demonstrated needs. For (resident T) the chart was reviewed and by utilizing the elopement risk tool, diagnosis, noted behaviors, and history of elopement; the service plan, assignment sheets, and chart	04/23/2011

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	Finding include: During the orientation tour 3/1/2011 at 9:55 a.m., Resident T was observed wandering the dementia unit's halls and staying near the main exit. He was observed going through the folding doors into the hall leading to the Assisted Living area which was beyond a locked door. He was agile and had a steady gait. LPN #2 indicated at the time they had started closing the inner set of folding doors to deter Resident T from staying near the locked door beyond. "It worked for a short while, but now he just goes through them." She indicated he was exit seeking nearly everyday, but had not eloped "except when a visitor let him off the unit onto the A.L. (Assisted Living) area. He never got out of the building." Resident T's clinical record was reviewed on 3/2/2011 at 10:35 a.m. It indicated he was admitted on 11/11/10. He had lived alone most of his life. His diagnoses, among others, included dementia of the Alzheimer's type with agitation and exit seeking behavior. His admission "Elopement Risk Assessment" 11/11/2010 directed the evaluator to multiply the scores from the two sections to obtain the final score. This had not been done. The form indicated a score of		were noted as to his elopement risk. Also, interventions have been put in place to enhance resident safety and to meet the resident's demonstrated needs. 2.All memory care/Keepsake Village residents' charts will be reviewed by the DON and/or designee to determine which residents are elopement risks. This will be completed by utilizing elopement risk tools, reviewing diagnosis and behaviors. After the residents are identified; the resident's service plans, assignment sheets, and charts will be updated to show elopement risk and interventions to be put in place to enhance safety and meet resident's needs. 3.On current residents; the service plans, assignment sheets, nursing assessments, and elopement tools are updated; per regulation, upon need, and upon change of condition. Elopement risks will be updated at this time and if necessary new interventions will be put in place. For new admissions; the service plans, assignment sheets, nursing assessments, and elopement tools will be completed along with assessment of resident, diagnosis, and any behaviors. When residents are identified as being an elopement risk; the service plan, assignment sheets and charts will be updated to show risks and interventions to be put in place to enhance resident safety and meet the resident's needs. 4.The DON and/or designee will do monthly audits on charts to ensure	

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	40 or above indicated a high risk for elopement and "Contact Administrator of Nursing immediately." Resident T's final score calculated out to 1152. Further, the form indicated that if "Even one of these items indicates a potential for elopement and requires consultation with the Administrator and Director of Nursing and appropriate intervention." Resident T scored on 4 of the 6 bolded items. Nursing note review indicated exit seeking behavior had presented when Resident T was admitted and had continued on a nearly daily basis since then. An entry on Wednesday 12/22/2010 at 2:30 p.m. recorded Resident T had eloped through a fire door during a fire alarm. How this occurred was not documented. It was thought he'd been outside 2-3 minutes before staff saw him and brought him back inside. There was no documentation of an assessment or what was done or how he had been dressed. Weather information obtained from the "History for KIND, Indiana" website 3/7/11 at 8 a.m. indicated there was approximately six inches of snow on the ground on 12/22/2010 in the Indianapolis area. The temperature at 1:24 p.m. was 24.8 degrees Fahrenheit with a wind speed of 12.7 miles per hour.		resident safety and to ensure resident's needs are being met. The systemic changes will be completed by April 23rd 2011	

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	Review of the nurse aide information/assignment sheets and the Service Plan was completed 3/2/2011 at 10:35 a.m. Review indicated wandering, exit seeking and elopement risk were not mentioned. During interview with the Director of Nursing on 3/2/2011 at 2:30 p.m. she indicated these forms were the residential facility's care plans. LPN #2 indicated during an interview on 3/2/11 at 11:30 a.m. their protocol during fire alarms was for a staff member to go directly to an exit door and make sure none of the residents exited, because as soon as the alarm sounded the doors automatically unlock. In addition, the kitchen staff, which are located adjacent to the unit, come to the unit as back up assistance. She again indicated Resident T had never gotten out. After reviewing the 12/22/2010 nursing note, she indicated she'd not known about it. Interview with the Director of Nursing on 3/2/2011 at 2:30 p.m. indicated she also was unaware Resident T had eloped outside on 12/22/2010. She indicated she has the responsibility of investigating and reporting such events and she was certain she had not known about this. After checking her records, she reported she			

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	had no investigation regarding Resident T. The Administrator was en route to an out of state meeting and unavailable for interview at that time. Interventions were discussed as well. The Director of Nursing indicated Resident T was not interested in group or individual activities or television, which made it difficult to redirect him from exit seeking. She indicated they had a psychologist evaluate Resident T shortly after admission. He had recommended an increase in the psychoactive medication which the attending M.D. then authorized. She indicated the psychologist usually recommended only medication interventions without behavioral modification suggestions. Staff usually gave him PRN (as needed) doses of an antianxiety medication as interventions when he was intense. This state residential finding relates to complaint number IN00084458.			