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 10/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF KOKOMO	3025 W. SYCAMORE STREET KOKOMO, IN46901

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R0000	This visit was for the investigation of complaint IN00098086. Complaint IN00098086 substantiated, state residential findings related to the allegations are cited at R0052. Survey dates: October 12 and 13, 2011 Facility Number: 011075 Provider Number: 011075 AIM Number: N/A Survey Team: DeAnn Mankell, R.N. Vicki Bickel, R.N. Census bed type: Residential: 34 Total: 34 Census payor type: Other: 34 Total: 34 Sample: 5 This state residential finding is cited in accordance with 410 IAC 16.2-5. Quality review completed 10/17/11 Cathy Emswiller RN	R0000	**The following is the Plan of Correction for Sterling House of Kokomo in regards to the Statement of Deficiencies for the complaint survey completed on 10/13/11. 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 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.**	

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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R0052	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review, observation, and interview, the facility failed to ensure a cognitively impaired resident, who was independently ambulatory, was supervised in a manner that ensured he would not be able to leave the building unattended and make his way to his home, seven miles away, unsupervised. This practice affected 1 of 4 residents with a dementia diagnosis in a sample of 5 (Resident A). Findings included: Resident A's closed clinical record was reviewed on 10/12/2011 at 10:30 A.M. Resident A's diagnoses included, but were not limited to, osteoarthritis, COPD (chronic obstructive pulmonary disease), prostate cancer, pacemaker, Alzheimer's dementia, vascular dementia, diabetes mellitus, hypertension, coronary artery	R0052	**R 052: 410 IAC 16.2-5-1.2 (v) (1-6) Resident Rights** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident A: This resident no longer resides at this community. · Immediately upon resident's safe return, the Executive Director initiated an investigation to determine the manner in which this resident had exited the community without alerting associates. · Exit doors as well as alarm systems were checked for appropriate functioning. · Investigation indicated that a family member had propped an exit door open, allowing the resident to leave through a door without sounding the usual alarm.. · Associates were re-educated by the Executive Director/Designee regarding the expectations of door monitoring during the move-in and move-out process. · Signs have been posted at main exits informing visitors that an associate	11/01/2011

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	disease, and GERD (gastroesophageal reflux disease). Resident A had been admitted to the facility on 8/20/2011. The cliental record contained a letter dated May 31, 2011, from the resident's physician, addressed to the resident's daughter indicating, "He has diagnosis of senile dementia of Alzheimer's type. He has been doing reasonably well. He is able to perform some of his ADL's (activities of daily living), but he is really not able to care for himself adequately on a lone basis...." Resident A's daughter was granted guardianship of the resident on January 7, 2011. Review of the Physician's orders upon admission to the facility indicated "Resident may not go on un-accompanied leave." Review of the "Optimum Life Personal History" dated 8/22/2011 indicated "Resident is alert & pleasant. Long term memory is inpaired (sic). Needs to be reminded of daily activities." Resident A's Interdisciplinary Progress Notes dated 8/27/2011 as a late entry at		must use a code to let them in or out of the community. In addition, visitors taking residents on LOA from the community are requested to sign in and out using the log available at the front entrance. Codes are not to be shared with vendors, residents or visitors. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Residents with cognitive impairment may have an increased potential to be affected by the alleged deficient practice. Since elopement is possible in any care setting, each resident may exhibit unique behaviors with the potential to indicate unmet needs: missing family, anxiety over losses, or confusion as to placement, which could increase potential for elopement. · Life Enrichment Programming and other prevention strategies that are resident-specific, may be helpful in addressing such needs and reducing risk of elopement. · The Personal Service plans of affected residents have been updated by the Health and Wellness Director/Designee where indicated. · In addition, the Regional Memory Care Specialist/Designee will provide an inservice to associates on "Elopement-risk Identification and Prevention Strategies, on October 26 th , 2011. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Cognitively impaired residents will be continue to be assessed by the	

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	4:40 P.M. indicated "Res. (resident) left the community without signing out through side door while another family was moving in. Res. stated a friend nane (sic) ' [stated person's name] took him home to visit. Res granddaughter returned res back to community." The facility had emailed an initial incident, dated 8/27/2011 at 2:00 P.M., to the ISDH (Indiana State Department of Health) indicating the resident had "Left community with out signing out, went home was gone 27 minutes family returned him to community. Resident reported that a friend took him to his house to visit. His name was [stated person's name]." The facility had emailed a follow-up to the incident to the ISDH indicating the resident had "Left community with out signing out, went home was gone 27 minutes family returned him to community. Resident reported that a friend took him to his house to visit. His name was [stated person's name]. After investigation it was discovered that (Resident A) left out of the service door which was open as new resident family members were moving in. They thought he was a visitor. He then returned back to the community with the family. At that time he was not sure who had brought		Health and Wellness Director/Designee, using the Personal Services Assessment, for wandering and exit-seeking behaviors prior to move-in, upon move-in, every 6 months, and with condition change. · In the event a resident is noted to be exhibiting exit-seeking behaviors, the Executive Director/Designee is to be notified. Responsible parties will be notified and may be required to provide a 1:1 sitter until such time as this behavior is resolved. · In the event it is determined, based on Personal Services Assessment, that resident needs cannot be met in the Residential Care setting, the physician and responsible parties will be notified of findings and assisted to find placement in a secured memory care setting or may chose to continue to utilize a third-party provider (as a 1:1 sitter) in the assisted living setting. · Elopement drills will continue to be conducted quarterly on each shift per existing policy. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · Personal Service Assessments for all new move-ins will continue to be reviewed by the Health and Wellness Director/Executive Director-- prior to move-in-- to assess the safety needs of potential residents. · Any pre-move-in assessment indicating resident has a known history of previous exit-seeking or wandering-type behavior is to be reviewed with the Regional Nurse/Regional VP prior to move-in to determine the most appropriate placement options. · Residents noted to have exit-seeking behaviors will receive an	

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	him to his house.... Preventive measures taken: Continued investigation due to resident's recall of leaving. Spoke with the daughter. At the time of discovery all door alarms were checked and found to be in proper working order. Staff was inserviced on monitoring the exit doors when families are moving in or out." There was a Door Policy effective August 31, 2011 which indicated "Effective immediately, if a family is moving in/out and wants the door open. You are to stand at the door or have another associate monitor the door. At no time should the door be left unattended. That means do not put anything in the door to hold it open...." During an interview with the Executive Director on 10/12/2011 at 11:15 A.M., she indicated the resident had left the building when the side door had been propped open by a family moving into the facility. He had walked by them out the door and they thought he was just a visitor. She indicated the resident's granddaughter had brought him back to the building from his home. She indicated the staff had seen him at 2:00 P.M. and he had been returned 27 minutes later. She indicated Resident A could not remember later how he had gotten to his home.		updated Personal Service Assessment to indicate a change of condition, and their Personal Service Plans and Care Profiles (available to all associates) will be updated to indicate interventions strategies unique to that individual. · The interdisciplinary team will review status of all residents using the Collaborative Care meeting process every 2 weeks and ongoing. · The Executive Director/Designee will be responsible for making additional recommendations based on findings. ***By what date will these systemic changes be implemented?*** · 11-1-11 **R0052 What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Resident # · Resident # How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · By what date will these systemic changes be implemented? ·**	

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	During an interview with Resident A's daughter on 10/12/2011 at 2:55 P.M., she indicated she was not in the state when this had occurred, but that she had received a phone call from her daughter's babysitter indicating Resident A was standing outside his house knocking on a window. She had let him in and had called Resident A's daughter. Resident A's daughter had called her daughter, who was living in Resident A's home with her son, and asked her to leave work and drive home and return Resident A to the facility. Resident A's home was located in the next town from the facility. There was a distance of 7 miles between the facility and the resident's home. Resident A's daughter was working in the town where the facility was located. She had returned the resident to the facility. She indicated Resident A could not remember how he got from the facility to his home. Resident A's daughter she had called the facility asking them if they knew where her father was and learned the facility did not know he was gone from the facility. During an interview with the Executive Director on 10/13/2011 at 9:15 A.M., she indicted the resident was gone longer than 27 minutes, as the family kept him at home for a while before returning him to the facility.			

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	Review of the policy for "Elopement Risk" dated July 2008 and provided by the Health and Wellness Director on 10/13/2011 at 10:00 A.M., indicated "1.... Any resident at a non-memory care community who has a documented diagnosis of dementia shall also be considered at risk for elopement. Residents as risk for elopement will be identified in their plan of care...." This state residential tag refers to complaint IN00098086.			