

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 05/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

R000000	<p>This visit was for the Investigation of Complaint IN00149488.</p> <p>Complaint IN00149488- Substantiated. State Residential deficiency related to the allegation are cited at R0052.</p> <p>Survey Dated: May 21, 2014</p> <p>Facility number: 002627 Provider number: 002627 AIM number: N/A</p> <p>Survey team: Regina Sanders, RN, TC Jennifer Redlin, RN Caitlyn Doyle, RN Heather Hite, RN</p> <p>Census by bed type: Residential: 117 Total: 117</p> <p>Census Payor type: Other: 117 Total: 117</p> <p>Residential Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R000000	<p><i>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 the proposed administrative penalty (with right to correct) on the community. 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 each allegation or finding. We have not presented all contrary factual or legal arguments, 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.</i></p>	
---------	--	---------	---	--

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.

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 05/21/2014	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
R000052	<p>Quality review completed on May 22, 2014 by Janelyn Kulik, RN.</p> <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from neglect, related to a confused resident who was exit seeking and frequently exited the facility unattended. The facility failed to initiate interventions to maintain the resident's safety for 1 of 3 residents reviewed for exit seeking/elopement risk, in a total sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 05/21/14 at 11 a.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus. The resident was admitted into the facility on 05/06/14 from the hospital.</p> <p>A hospital History and Physical, dated 05/03/14, indicated the resident had progressive confusion, likely related to</p>	R000052	<p><i>R 036 Residents' Rights-Offense What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Resident B has been relocated permanently to the communities secured memory care neighborhood. 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? · All assisted living residents have been reviewed by the RCD and ED on 5/22/14 for exit seeking behaviors and none were identified. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · Employees will be re-educated on 5/30/14 regarding resident safety and elopement policy and</i></p>	05/30/2014			

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 05/21/2014	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>dementia and had a history of short term memory problems.</p> <p>The facility Pre-Admission Assessment, dated 05/01/14, indicated the resident had dementia, had periods of confusion/forgetfulness, and had independent mobility.</p> <p>The Admission Care Level Assessment, dated 05/06/14, indicated the resident had periods of confusion.</p> <p>The Nurses' Progress Notes indicated:</p> <p>05/07/14 at 2:30 p.m.-"Res. (resident) went outside earlier, looking for his keys, wanting to go for a walk et (and) mentioning his car...Concierge reported res. went to the east unit 3x's attempting to go outside et referring to his keys..."</p> <p>05/07/14 at 5:30 p.m.- "Informed by Eastside Nurse that resident was seen urinating in the grass in front of the building. Found sitting in the sun..."</p> <p>05/07/14 at 7 p.m.- "Resident came to station wanting to leave..."</p> <p>05/08/14 at 2:40 p.m.- "...does require redirecting & constant reminders..."</p> <p>05/08/14 at 8:30 p.m.- "...continues to</p>		<p>procedure · Nursing staff to notify ED or RCD immediately if any resident exhibits exit seeking behavior. · RCD or designee will review residents with exit seeking behaviors Monday- Friday during management meeting.* The Manager on duty will review residents with exit seeking behaviors on weekends and Holidays and notify the ED and RCD immediately if any are identified. 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? · The RCD will identify any resident exhibiting exit seeking behavior at the communities monthly CQI meeting to monitor for appropriate interventions for the residents safety, this will be ongoing. By what date will these systemic changes be implemented? · Implemented 5/30/14</p>				

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 05/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>have to be redirected, goes out of building on Eastside. Pacing the halls, looking for his car...Asking visitors to call him a cab..."</p> <p>05/11/14 at 11:30 a.m.- "Sent RA (Resident Assistant) to residents room to check on him at 11 a.m. Resident was not in his room. Found resident sitting outside on the east side when he stated to her that he took a walk around the hospital (pointing in that direction) 2 x's looking for his car but couldn't find it...Called & left a message c/ (with) daughter..."</p> <p>05/13/14 at 1:40 p.m.-Writer found resident walking outside, car keys in hand, 0/ (no) jacket on (cool-out). Resident stated he was looking for his car, and he was ready to go home...ED (Executive Director) aware. Left a msg (message) for dtr (daughter) (Name) to call back et to expect a call from the MCD (Memory Care Director) (locked unit)"</p> <p>05/13/14 at 5 p.m.- "...pacing & looking for his car outside..."</p> <p>05/16/14 at 5:30 p.m.- "Resident went out the front door, around the Southside of the building across the Eastside et headed toward the hospital stating he was</p>			

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 05/21/2014	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>going to get his car, writer was following resident et he was stating thanks, but I won't be back..."</p> <p>05/16/14 at 6:30 p.m.-"Resident left the building again et refusing to be re-directed. MCD & ED (Executive Director) interveined (sic). MCD got resident to get in car et took him for ice cream..."</p> <p>The Nurses' Note, dated 05/16/14 at 7:15 p.m., indicated the ED had spoke with the resident's family over concerns about the resident's safety and the family agreed to the resident being kept on the Memory Care Unit until the doors of the the Assisted Living Unit were locked.</p> <p>During an interview on 05/21/14 at 11 a.m., the ED indicated the doors in the Assisted Living Unit locked at 8 p.m. every night.</p> <p>The Nurses' Note, dated 05/16/14 at 8:45 p.m., indicated the resident was assisted to his room on the Assisted Living Unit from the Memory Care Unit. (The resident then eloped at least four times after this intervention)</p> <p>A Nurses' Note, dated 05/16/14 at 11 p.m., indicated the resident was talking about walking to his house to get his car.</p>						

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 05/21/2014	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>A Nurses' Note, dated 05/17/14 at 12 p.m., indicated the resident was going home and the staff attempted to redirect him back to the building and he refused but after five tries the resident came back into the building.</p> <p>A Nurses' Note, dated 05/17/14 at 8 p.m., indicated the resident returned to the facility with no problems.</p> <p>There was a lack of documentation to indicate the facility had initiated further interventions to ensure the resident's safety.</p> <p>A Note written by the ED, dated 05/18/14 and late entry from 05/17/14, indicated she had met with the resident's family and the family was made aware of the safety concerns of the resident trying to walk to his home to get his car. The note indicated the resident agreed to get transportation from community or friends if he wants to go somewhere and he will sign out per the community policy. The note indicated the resident said he would not try to walk home alone again.</p> <p>A Nurses' Note, dated 05/18/14 at 10 p.m., indicated the resident was missing from the facility around 8:53 p.m. The note indicated the resident had been seen</p>						

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 05/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>by the nurse at approximately 8:05 p.m. The note indicated the resident was located approximately two miles from the facility at 9:05 p.m. The family was notified and were given options of having someone come and sit with the resident, discharge the resident to home, or the facility would need to transfer the resident to the Memory Care Unit. The note indicated the family were informed the transfer to the Memory Care Unit would be permanent as long as he was a resident of the facility. The note indicated the resident was then transferred to the Memory Care Unit.</p> <p>During an interview on 05/21/14 at 12:20 p.m., the ED indicated based on the resident's cognitive status, the residents in the Assisted Living can leave when they want. She indicated the residents are required to sign themselves out of the building. She indicated she had not been notified of the resident's exit seeking or elopements until 05/13/14. She indicated she was not sure if anyone had thought about transferring the resident to the Memory Care Unit when he continued to elope out of the building.</p> <p>During an interview on 05/21/14 at 12:55 p.m., the ED indicated she had not returned from vacation until 05/12/14. She indicated no one had informed her</p>			

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 05/21/2014	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>nor called her to report the elopements. She indicated the Resident Care Directors last day of employment was 05/11/4 and the Memory Care Director had filled in until the new Resident Care Director started employment at the facility. She indicated there had not been interventions initiated for the safety of the resident related to the elopements. She indicated there was not a policy for residents with exit seeking and elopement risks, due to residents with these behaviors should not be living in the Assisted Living Unit. She indicated the staff should have called her when the resident eloped. She indicated the resident should have been transferred to the Memory Care Unit after the first or second attempt.</p> <p>During an interview on 05/21/05 p.m., the Memory Care Director indicated she was not aware of the resident's frequent elopements. She indicated had she been aware of the exit seeking behaviors and the elopements she would have talked with the family about the Memory Care Unit.</p> <p>This Residential Tag relates to complaint IN00149488..</p>						

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 05/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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