

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 06/30/2016
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NAME OF PROVIDER OR SUPPLIER BROOKDALE RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 S A ST RICHMOND, IN 47374
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00203189.</p> <p>Complaint IN00203189 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: June 28, 29, and 30, 2016</p> <p>Facility number: 010888 Provider number: 010888 AIM number: N/A</p> <p>Census bed type: Residential: 40 Total: 40</p> <p>Census payor type: Other: 40 Total: 40</p> <p>Sample: 4</p> <p>This state finding is cited in accordance with 410 IAC 16.2-5</p> <p>Quality review completed by 30576 on July 6, 2016</p>	R 0000	<p>The following is the Plan of Correction for Brookdale Richmond of the Deficiencies dated June 30, 2016. The 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 and regulatory requirements. In this document, we have outlined specific actions in response to statutory 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 improvements to satisfy that objective.</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.

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R 0052 Bldg. 00	<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 adequate supervision was provided to prevent the elopement of one resident who had been displaying exit seeking behaviors and had verbalized a desire to leave the facility. This affected 1 of 1 resident who was at risk for elopement. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 6/29/16 at 4:15 p.m. The record indicated Resident #C was admitted on 4/14/16. Physician's orders dated 6/1/16 through 6/30/16 indicated Resident #C's diagnoses included, but were not limited to, dementia, gastro-esophageal reflux</p>	R 0052	<p>R052 Resident # Cis no longer in the community. The Faulty exit doors were fixed on June 10, 2016 and alarms were set to alarm on staff's notification system. Immediately after elopement attempt staff were re-educated on May 18, June 8 and July 13, 2016 in-service on Brookdale elopement policy and the new alarm system. The maintenance director will monitor and document function of doors monthly ongoing, the health and wellness director or designee will monitor resident's that are at risk for elopement and place appropriate interventions in place per Brookdale policy. Resident identified as an elopement risk will be reviewed and monitored bi-weekly in Collaborative Care review meeting and Documentation of the function of</p>	07/01/2016

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	<p>disorder, depression, and constipation.</p> <p>Physician's orders included an activity level for "May not go on un-accompanied leave."</p> <p>A "Personal Service Plan", dated 4/14/16, did not indicate Resident #C would wander or be an elopement risk.</p> <p>A "Personal Service Plan", dated 4/28/16, indicated, but was not limited to: "...Cognitive/Psychosocial: Resident needs help to participate in community activities because of memory loss...Resident wanders and requires redirection...Provide support to families regarding the common nature of these behaviors in residents with dementia, cognitive impairment or memory loss...Resident has elopement on 4-19-2016...needs redirection when wandering. Resident enjoys watching TV in her room. Increased rounding every shift to know residents whereabouts. Encourage resident to participate in activities. Behavior Management: Resident attempts to exit building without needed supervision. Resident is exit seeking at times - needs redirection. Encourage resident to participate in activities - enjoys watching TV and talking to fellow residents...."</p>		<p>exit doors will be reviewed. Date of compliance: July 1, 2016</p>	

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	<p>Interdisciplinary Progress Notes, dated 4/15/16 at 11:35 a.m., indicated: "...Pleasantly confused. [No] c/o (complaints) voiced...[Up] ambulating throughout community..."</p> <p>Interdisciplinary Progress Notes, dated 4/17/16 at 7:10 p.m., indicated: "Left message for daughter. Res. (resident) is exit seeking."</p> <p>Interdisciplinary Progress Notes, dated 4/19/16 at 2:20 p.m., indicated: "RCA (Resident Care Assistant) #1 came into this writers office stating that on her way to work, she noticed a woman walking down the sidewalk that resembled [Resident #C]. This writer immediately alerted staff to search community for resident. While staff continued searching community, [RCA #1] and this writer left the community and returned to the place that [RCA #1] thought she saw resident. Res was found walking down the sidewalk. This writer and [RCA #1] brought res back to community." This entry was signed by LPN #2.</p> <p>Interdisciplinary Progress Notes, dated 4/19/16 at 2:45 p.m., indicated: "Upon return to community, resident was assessed. Vitals taken and were as follows: B/P (blood pressure) 98/53, R (respirations) 20, P (pulse) 92, Spo2</p>			

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	<p>(oxygen saturation levels) 96%, on RA (room air). Res denies pain or discomfort. Head to toe skin assessment complete and [no] areas of concern noted. Res stated that she was "just tired" from walking. Res given ice water and a snack. Res returned to her room and sat in recliner [with] her feet propped up. Res reported to this writer that she was "going home".</p> <p>An elopement investigation, dated 4/19/16, was provided by the Executive Director on 6/29/16 at 11:00 a.m. The investigation indicated RCA #1 noticed a woman walking down the sidewalk that resembled Resident #C. Staff were alerted and RCA #1 and LPN #2 returned to the place where the resident was seen, and the resident was found walking down the sidewalk. They returned the resident to the community. The Executive Director was notified. Resident was assessed upon return to the facility, no areas of concern noted. The POA (Power of Attorney) and physician were notified by phone of the resident's elopement. Resident was placed on one on one supervision. The interventions were to place the resident on 1-1 companion care for 24 hours, move to once an hour, then to every two hours, and for the resident not to exit seek during the 1-1 and hourly checks.</p>			

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	<p>Interdisciplinary Progress Notes, dated 4/19/16 at 5:00 p.m., indicated: "Res down to DR (dining room) for dinner. Ate 75%. Denies pain or discomfort. Continues 1:1 supervision. [No] attempts made to exit building."</p> <p>Interdisciplinary Progress Notes, dated 4/19/16 at 8:00 p.m., indicated: "ED (Executive Director) confirmed that [a local home health agency] will be coming to provide 1:1 companion care. RCA doing 1:1 now and will continue X 24 hours."</p> <p>Interdisciplinary Progress Notes, dated 4/26/16 at 4:02 p.m., indicated: "Res seen at 600 door looking outside. Nurse intercepted & took Res to courtyard to sit."</p> <p>An observation of the courtyard indicated it is completely enclosed by the building, and residents would have to come back into the facility to leave the building.</p> <p>Interdisciplinary Progress Notes, dated 5/1/16, at 3:30 p.m., indicated: "Resident pushing on door until alarm sounded. Staff redirected inside...Charting on resident Q (every) hour."</p> <p>Interdisciplinary Progress Notes, dated</p>			

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	<p>5/26/16 at 2:20 p.m., indicated: "Resident is having exit seeking behaviors @ this X (time). Going from door to door banging & pushing on door, asking employee's & other residents to let her out the door. Redirection unsuccessful. ED made aware. POA, [Name of POA] called & made aware. She is on her way to come visit [with] resident. Sitting in court yard area @ this X [with] another resident - Resident in view of staff."</p> <p>Interdisciplinary Progress Notes, dated 5/26/16 at 7:30 p.m., indicated: "Res. cont[inues] to exit seek. Is observed going door to door attempting to open. Redirected by staff & given activity to do."</p> <p>Interdisciplinary Progress Notes, dated 5/26/16 at 9:00 p.m., indicated: "Res. wandering hallways. Refuses to allow staff to assist [with] HS (bedtime) care & put p.j.'s on. In apt. (apartment) @ this time watching T.V."</p> <p>Interdisciplinary Progress Notes, dated 6/9/16 at 8:00 p.m., indicated: "Res. has been exit seeking this shift. Wants writer to let her out front door. Witnessed res. push on door to try to open X3. Gives up when door doesn't open."</p>			

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	<p>Interdisciplinary Progress Notes, dated 6/10/16 at 1:30 p.m., indicated: "Res ate lunch - 100%. CNA [#3] was cleaning up dining when she noticed Res standing by front door. She redirected Res away from the door. This writer then took her & sat her on the couch [with] a fellow Res to visit."</p> <p>Interdisciplinary Progress Notes, dated 6/10/16 at 2:10 p.m., indicated: CNA [#3] visualized Res standing @ the front door again. She then took her & sat her on the couch to visit [with] fellow residents."</p> <p>Interdisciplinary Progress Notes, dated 6/10/16 at 2:45 p.m., indicated: "ED observed Res walking by [a local park]. ED returned to facility [with] Res. Res found to be out of the Bldg (building) for 45 minutes. Head to toe assessment completed. [No] injury noted. Res voiced [no] c/o (complaints) from incident. Res verbalized she doesn't know how she got out of the Bldg...."</p> <p>Interdisciplinary Progress Notes, dated 6/10/16 at 3:36 p.m., indicated: "...Upon return to the Bldg, ED & CNA [#3] found the carport door to be faulty & not in working order."</p> <p>Interdisciplinary Progress Notes, dated</p>						

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	<p>6/10/16 at 4:00 p.m., indicated: "Staff member here to do 1 on 1 [with] Res."</p> <p>An "Elopement Investigation" dated 6/10/16, was provided by the Executive Director on 6/29/16 at 11:00 a.m. The investigation indicated the Executive Director was driving to the facility and saw Resident #C walking down the side walk less than a mile from the facility. She brought the resident back to the facility in her car. The resident was last seen in the living room area at 2:10 p.m. They checked all the alarmed doors and found one that was faulty and called the company who repairs the doors to come in and repair the door immediately. The company found the carport door magnet was not latching and the alarm was not properly alarming. The resident was placed on 1-1 companion with staff until her daughter came to pick her up for leave of absence, when she returned from leave of absence, the resident was placed on one to two hour checks until she was moved on 6/21/16 to another facility.</p> <p>During an interview, on 6/28/16 at 3:10 p.m., the Maintenance Tech indicated all (outside) doors are alarmed. The doors have a magnetic device that keeps the doors closed so they can't be opened, unless pushed on for 15 seconds, then the doors will open for an emergency. All</p>			

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	<p>care associates carry a cordless phone; if an outside door is opened, the cordless phone indicates that door number. If the door is pushed on for 15 seconds, the alarm will continue until deactivated.</p> <p>During an interview, on 6/28/16 at 3:47 p.m., the Executive Director indicated it was helpful for Resident #C to be redirected if she was exit seeking, and they also called her daughter who would come in. Staff did one on one with her, then Resident #C's daughter found a more secure building for her.</p> <p>During an interview, on 6/29/16 at 11:13 a.m., the Health and Wellness Director indicated on 4/19/16, they had checked the doors and all were working fine. They found out some family members had the code so they changed the code that day. They changed the code after the first elopement, and told staff not to let families see what the code was. After the second elopement, they called the company that repairs the doors, and they repaired it immediately.</p> <p>During an interview, on 6/30/16 at 1:08 p.m., the Executive Director indicated they were not sure if it was the door or if Resident #C walked out with people from a church in April. In June, Resident #C told the Executive Director she was going</p>			

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	<p>for a walk.</p> <p>A policy and procedure, for "Missing Resident Policy", was provided by the Executive Director on 6/29/16 at 12:10 p.m. The policy included, but was not limited to: "Policy Overview: It is the policy of Brookdale to ensure the safety of residents. A missing resident requires immediate associate attention. If associates discover a resident's whereabouts are unknown, associates must immediately begin to follow the procedures of the Missing Resident Policy. A visual (face to face) observation of the missing resident is considered confirmation that the resident has been found...."</p> <p>This Residential tag relates to Complaint IN00203189.</p>				