

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155076	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/20/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00184761.</p> <p>This visit resulted in a Partially Extended Survey-Substandard Quality of Care-Immediate Jeopardy.</p> <p>Complaint IN00184761- Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226 and F323.</p> <p>Survey dates: October 16, 17, and 18, 2015 Partially extended survey dates: October 19 and 20, 2015</p> <p>Facility number: 000031 Provider number: 155076 AIM number: 100266150</p> <p>Census bed type: SNF/NF: 106 Total: 106</p> <p>Census payor type: Medicare: 7 Medicaid: 80 Other: 19 Total: 106</p>	F 0000		

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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F 0225 SS=D Bldg. 00	<p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on October 23, 2015.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>				

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	<p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an elopement was immediately reported to the Executive Director by a staff member when the resident was first noted to be absent, and when notified the Executive Director failed to ensure the event was promptly reported to the Indiana State Department of Health Long term Care. 1 of 3 resident's reviewed for elopement. (Resident #B)</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 10/16/15 at 12:00 P.M. Diagnoses, obtained from an Admission Record dated 10/14/15, included, but were not limited to, dementia with behavioral disturbance, Alzheimer's Disease, hypertension, angina, coronary artery disease, and chronic obstructive pulmonary disease.</p> <p>A timeline of events related to Resident #B was provided by the Director of</p>	F 0225	<p><b>F225 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <p>Interviews were conducted by the Director of Nursing Services (DNS) of staff that worked while Resident #B was at the facility. LPN #5 did not observe resident for entire 2pm-10pm shift on 10/15/15 nor did he administer scheduled medications. He only notified Executive Director (ED) after night shift RN was doing census and asked where the resident was. The other nurses that worked on the unit of Resident #B, the Rehab Unit, from the time of the admission of Resident "B until his elopement were interviewed. The C.N.A #4 that worked 10/15/15 2pm-10pm shift was interviewed and stated that she thought the resident was LOA with family and did not question his absence the entire shift. <b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are</b></p>	11/06/2015

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	<p>Nursing Services on 10/19/15 at 10:45 A.M., and indicated by her to be an accurate accounting of the events related to the elopement of Resident #B. Information in that timeline was obtained through interviews conducted by facility executive staff. It included, but was not limited to:</p> <p>10/15/15 3:00 P.M. "(LPN #5) Did not administer (named medications) as ordered, when asked why he did not question the location of the resident, (LPN #5) stated, (CNA #4) said he was gone out of the building with family.' Upon interview with both (CNA #4) and (LPN #5), she (LPN #4) maintains she never made that statement and (LPN #5) acknowledges he may have misunderstood her. (CNA #4) is at times difficult to understand due to English being her second language."</p> <p>10/15/15 11:30 P.M. "He (LPN #5) stated that his Unit Manager had left him some paperwork that needed to be done and a part of that was the paperwork on (Resident #B), he stated it was at that time he questioned where the resident was and why he had not 'returned' to the facility, as he thought he heard (CNA #4) say he was out with family."</p> <p>10/15/15 11:45 P.M. "(LPN #5) Notified ED (Executive Director) That (Resident #B) was not in the facility. ED instructed (LPN #5) to initiate a search of the unit</p>		<p><b>as follows:</b> LPN #5 was suspended and received a disciplinary action and was terminated from employment on 10/20/15. A letter was sent to the Indiana Professional Licensing Board on 10/23/15 regarding the incident. ED, AIT, DNS in-serviced on 11/5/15 by Clinical Specialist Consultant on timely reporting of incidents to ISDH. <b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b> LPN #5 was suspended and received a disciplinary action and was terminated from employment on 10/20/15. A letter was sent to the Indiana Professional Licensing Board on 10/23/15 regarding the incident. ED, AIT, DNS in-serviced on 11/5/15 by Clinical Specialist Consultant on timely reporting of incidents to ISDH. All new employees will be in-serviced on the elopement policy during orientation. All employees will be in-serviced on elopement procedures annually, and as needed in response to attempted elopements. <b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b> All staff will be able to verbalize knowledge of elopement procedure. Elopement drills will be completed</p>				

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	<p>while ED awaited results. (LPN #5) returned to telephone and informed ED that resident was not on the unit. ED then instructed that he would be in the facility within 15 minutes and to initiate an ALL facility search."</p> <p>The Executive Director (ED) and Area Vice President were interviewed on 10/16/15 at 3:00 P.M. The ED indicated Resident #B had eloped from the facility sometime on the afternoon of 10/15/15, and that he remained missing. The ED indicated that admission documentation indicated Resident #B had a diagnosis of dementia and was an identified elopement risk. The ED indicated both family and police had indicated Resident #B had an established pattern of disappearing and fraternizing with the homeless and street people of the Near East Side of Indianapolis, and he would typically be gone until his resources ran out. The ED indicated staff had not followed facility policy and procedure in not providing a Roam Guard device for a resident known to be an elopement risk, not maintaining awareness of his presence, and not promptly instituting a search and notifying management when he was first noted to be missing from the facility.</p> <p>LPN #5 was interviewed by this writer on</p>		<p>on each shift monthly for 2 months (October and November), then quarterly. DNS or designee will audit the elopement drills monthly for 2 months (October and November), then quarterly to ensure compliance. DNS or designee will randomly ask elopement questions to 5-10 staff members 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly to ensure knowledge of elopement procedures and provide further education as needed. Elopement procedure, including in-servicing, staff knowledge, drills, and events will be reviewed, analyzed, and summarized for the monthly Living Center QAPI Committee to ensure the appropriate process improvement actions are taken. <b>The systemic changes will be completed:</b> November 6, 2015.</p>				

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	<p>10/20/15 at 2:00 P.M. He indicated that on 10/15/15 he arrived 30 minutes late for his afternoon shift, and that LPN #3, who he was following, had left the unit to work on another unit, and he did not get report from her. He indicated that when he went to the unit where she was working to get the unit keys, LPN #3 told him "everything was ok" and gave him no other information. LPN #5 indicated that Resident #B's name "popped up" (on the computer) for 5:00 P.M. medications, but that he did not look for Resident #B, because, in his words, "other names popped up too, some were discharged." He indicated that when the night shift nurse, who came on at 10:00 P.M., began her daily census at "around 11:30 P.M." was when he was first aware Resident #B was missing. He indicated at that time he notified the ED and began a building search for Resident #B.</p> <p>On 10/16/15 at 10:27 A.M., the Executive Director reported through the Indiana State Department of Health web based Survey Reporting System an initial report regarding the elopement of Resident #B, who was identified as missing from the facility on 10/15/15 at 11:45 P.M. The ED indicated that between his notification of the incident on 10/15/15 at 11:45 P.M. and his reporting of the incident to the ISDH</p>			

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F 0226 SS=D Bldg. 00	<p>Long term Care on 10/16/15 at 10:27 A.M. he was actively involved in the search for Resident B, and he did not delegate the task of reporting the incident to another staff member.</p> <p>This Federal tag relates to Complaint IN00184761.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure facility policies and procedures were followed to ensure the safety of a resident who was an identified elopement risk. 1 of 3 residents reviewed for elopement. (Resident #B)</p> <p>Findings include:</p> <p>On 10/16/15 at 10:27 A.M., the facility reported through the Indiana State Department of Health web based Survey Reporting System an initial report regarding the elopement of Resident #B,</p>	F 0226	<p><b>F226</b></p> <p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <ul style="list-style-type: none"> <li>· 10/15/15, 11:45pm, ED notified by LPN#5 that Resident #B was not on his unit, the Rehab Unit.</li> <li>· 10/15/15, 11:45pm, facility search and grounds search at the</li> </ul>	11/06/2015

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	<p>who was identified to be an elopement risk. The report indicated that on 10/15/15 at 11:45 P.M., Resident #B was identified as missing from the facility. The report indicates the Executive Director, Director of Nursing Services, and the Indianapolis Metropolitan Police were notified. A search was instituted, the resident's guardian (the Center for At Risk Elders) was contacted, and attempts were made to contact the resident's family.</p> <p>The record of Resident #B was reviewed on 10/16/15 at 12:00 P.M. Diagnoses, obtained from an Admission Record dated 10/14/15, included, but were not limited to, dementia with behavioral disturbance, Alzheimer's Disease, hypertension, angina, coronary artery disease, and chronic obstructive pulmonary disease.</p> <p>A timeline of events related to Resident #B was provided by the Director of Nursing Services on 10/19/15 at 10:45 A.M., and indicated by her to be an accurate accounting of the events related to the elopement of Resident #B. Information in that timeline was obtained through interviews conducted by facility executive staff. It included, but was not limited to: 10/14/15 7:15 P.M. "...(Resident #B)</p>		<p>7145 East 21st street location initiated.</p> <ul style="list-style-type: none"> <li>· 10/16/15, 12:00am, ED arrived at facility and assisted staff with facility and grounds search.</li> <li>· 10/16/15, 12:00am, all family member phone numbers listed on Golden Living and Community Hospital Face Sheets were called by ED.</li> <li>· 10/16/15, 12:45am, ED notified Indianapolis Metropolitan Police Department of the elopement of Resident #B - IMPD officer arrived at the facility.</li> <li>· 10/16/15, 12:52am, ED drove to 2914 English Avenue, which was the address listed on the Face Sheet of Resident #B.</li> <li>· 10/16/15, 2:15am, IMPD officer returned to facility, providing case #DP15120231.</li> <li>· 10/16/15, 2:45am, ED initiated in-servicing of all night shift nurses and C.N.A's present, on elopement guideline and reporting procedure.</li> <li>· 10/16/15, 5:45am, ED continued in-servicing with day shift nurses, CNA's, dietary staff, and housekeeping staff, with no staff working before being in-serviced.</li> </ul>	

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	<p>arrived at (the facility)...Diagnosis (sic) listed: HTN, COPD, Depression with behavioral disturbance, SOB, chest pain. Per assessment (Resident #B) was at risk for elopement. Roam guard, (an electronic device intended to be worn by residents who are at risk for elopement; if the resident approaches an external door, a warning is sounded, and the door locks. If the resident exits an open door, a facility wide alarm sounds) per (Facility) Elopement Guideline, should have been placed on (Resident #B) at that time....Per interview with (LPN #1) there was not a Roam Guard on the medication chart for the Rehab unit. When asked if she checked the other units medication chart she stated 'No.' When asked if she tried to contact anyone about where she could locate a Roam Guard, (LPN #1) stated. 'no.'</p> <p>10/15/15 6:00 A.M. "During verbal report from night shift nurse (LPN #1) was told by (RN #2) that due to confusion about wanting to see his wife, that the resident (Resident #B) should have a roam guard. (LPN #1) states she was on the unit until about 9:45 A.M., and was then relieved by (LPN #3), and during verbal report she told (LPN #3) that (Resident #B) should have a Roam Guard. When (LPN #1) was asked if she asked for a Roam Guard from the Unit Manager, DNS (Director of Nursing</p>		<ul style="list-style-type: none"> <li>· 10/16/15, 7:30am, at daybreak, staff continued search of grounds and surrounding properties and neighborhood, businesses. Staff also drove to 2813 Meredith Avenue address found in Resident #B's hospital information.</li> <li>· 10/16/15, 9:10am, all family member phone numbers listed on Golden Living and Community Hospital Face Sheets called again by ED.</li> <li>· 10/16/15, 9:10am, staff contacted taxi companies and bus companies to inquire about fares picked up outside facility.</li> <li>· 10/16/15, 9:10am, staff contacted Community Hospital East, Community Hospital North, Eskenazi Hospital, IU Methodist, St. Vincent Hospital, St. Francis Hospital, and Westview Hospital about possible admission of Resident #B.</li> <li>· 10/16/15, 9:15am, staff contacted Wheeler Mission, Good News Mission, and Salvation Army about Resident #B.</li> <li>· 10/16/15, 9:30am, staff again drove to English Avenue address, Meredith Avenue address, Bradbury Avenue address, and surrounding streets.</li> <li>· 10/16/15, 10:00am, ED notified Center for At-Risk Elders</li> </ul>	

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	<p>Services) or ED (Executive Director), all of which were present in the building (LPN #1) stated that she did not request the Roam Guard from any Department Manager."</p> <p>10/15/15 2:00 P.M. "...Stated she (CNA #4) never did see (Resident #B). That his bed was made and room appeared as though no one was occupying the room. (Resident #B's) name tag was on the outside door."</p> <p>10/15/15 2:25 P.M. "'I (LPN #3) was standing at the treatment cart...(Resident #B) was standing at the doorway of his room...I told him I would be there in a few minutes to finish his paperwork...' When asked if she did go to the room to complete it, (LPN #3) stated, 'no I got moved to ACU.'"</p> <p>10/15/15 2:30 P.M. "(LPN #5) Arrived to work, went to ACU to receive report from (LPN #3)...per (LPN #5) she (LPN #3) stated 'Everything was okay.'"</p> <p>10/15/15, between 2:00 P.M., and 4:00 P.M., from facility interviews with residents #J and #K: "Both these residents were on the porch outside the Rehab unit and noted the resident walking across the parking lot. Both noted he did not exit the rehab unit door, but appeared as though he had exited the main door. Resident K stated 'I yelled at him...' but he did not answer...Both stated they never saw him again and both</p>		<p>about elopement of Resident #B.</p> <ul style="list-style-type: none"> <li>· 10/16/15, 10:27am, ED submitted initial report to ISDH.</li> <li>· 10/16/15, 10:30am, ED spoke with IMPD detective assigned to elopement of Resident #B.</li> <li>· 10/16/15, 12:00pm, ED spoke with additional family members.</li> <li>· 10/16/15, 12:30pm, staff drove to Salvation Army, Good News Mission, Big Lots Plaza, Twin Aire Plaza, Kroger, McDonalds, English Avenue address, and surrounding streets.</li> <li>· 10/16/15, day and evening, staff continued drives to the Twin Aire Plaza area of English Avenue, Southeastern Avenue, and Rural Avenue. Staff continued telephone calls to family members.</li> <li>· 10/17/15, all day and evening, staff continued drives to the Twin Aire Plaza area of English Avenue, Southeastern Avenue, and Rural Avenue. Staff continued telephone calls to family members.</li> <li>· 10/17/15, 10:30am, ED learned that the Twin Aire Plaza Kroger Customer Service Manager posted on social media that she saw and spoke with Resident #B. ED drove to Kroger and interviewed Manager, who stated that she saw</li> </ul>	

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	<p>gentlemen stated they did not tell anyone about this..."</p> <p>10/15/15 3:00 P.M. "(LPN #5) Did not administer (named medications) as ordered, when asked why he did not question the location of the resident, (LPN #5) stated, '(CNA #4) said he was gone out of the building with family.' Upon interview with both (CNA #4) and ((LPN #5), she (LPN #4) maintains she never made that statement and (LPN #5) acknowledges he may have misunderstood her. 'CNA #4) is at times difficult to understand due to English being her second language.'"</p> <p>10/15/15 11:30 P.M. "He (LPN #5) stated that his Unit Manager had left him some paperwork that needed to be done and a part of that was the paperwork on (Resident #B), he stated it was at that time he questioned where the resident was and why he had not 'returned' to the facility, as he thought he heard (CNA #4) say he was out with family."</p> <p>10/15/15 11:45 P.M. "(LPN #5) Notified ED (Executive Director) That (Resident #B) was not in the facility. ED instructed (LPN #5) to initiate a search of the unit while ED awaited results. (LPN #5) returned to telephone and informed ED that resident was not on the unit. ED then instructed that he would be in the facility within 15 minutes and to initiate an ALL facility search."</p>		<p>Resident #B on 10/15/15 at about 5pm, and he informed her he rode the city bus to Twin Aire Plaza at that time.</p> <ul style="list-style-type: none"> <li>· 10/17/15, 11:15am, ED drove to other Twin Aire Plaza businesses and 3834 Spann address provided by Kroger Manager, as well as homeless tent areas, World Mission Thrift Store, Christian Park, and New Crown Cemetery.</li> <li>· 10/18/15 – 10/24/15, staff continued daily drives to English Avenue, Southeastern Avenue, Rural Avenue area, Twin Aire Plaza area, Kroger, McDonalds, Big Lots Plaza, New Crown Cemetery, and missions. Staff continued daily calls to family members.</li> <li>· 10/24/15, 4:12pm, ED contacted by Twin Aire Plaza Kroger Customer Service Manager that Resident #B was in store, and 911 called.</li> <li>· 10/24/15, 6:45pm, ED contacted by IMPD officer that Resident #B had been located, detained, checked medically by EMT's at scene. ED informed officer of elopement, medical diagnoses of Resident #B, Missing Persons Report, IMPD investigation, and the need for Resident #B to be taken to a hospital or returned to facility. Officer stated that Resident #B did not appear disheveled or ill, seemed to be</li> </ul>	

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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	<p>10/16/15 12:00 A.M. " ED arrived at facility and initiated an external premises search..."</p> <p>10/16/15 12:45 A.M. "ED notified Indianapolis Metropolitan Police Department. (Officer) arrived at facility to take report."</p> <p>10/16/15 12:52 A.M. "Notified Area Vice President...in route to (addresses from admission records.)"</p> <p>10/16/15 2:15 A.M. "(Officer) returned to facility, provided case number...stated he had discussed the report with his sergeant, and that a detective would be contact ED." (sic)</p> <p>The Executive Director (ED) and Area Vice President were interviewed on 10/16/15 at 3:00 P.M. The ED indicated Resident #B had eloped from the facility sometime on the afternoon of 10/15/15, and that he remained missing. The ED indicated that admission documentation indicated Resident #B had a diagnosis of dementia and was an identified elopement risk. The ED indicated both family and police had indicated Resident #B had an established pattern of disappearing and fraternizing with the homeless and street people of the Near East Side of Indianapolis, and he would typically be gone until his resources ran out. The ED indicated staff had not followed facility policy and procedure in</p>		<p>oriented and spoke clearly, and that Resident #B did not want to go to hospital or to facility. Officer stated he could not legally detain Resident #B since he seemed oriented and was responding appropriately. ED informed officer that the Center for At-Risk Elders was the guardian for Resident #B and they had placed him in the care of the facility.</p> <ul style="list-style-type: none"> <li>· 10/24/15, 7:15pm, ED contacted by the Center for At-Risk Elders Executive Director that Resident #B was released to the care of his grandson.</li> <li>· 11/6/15, 12:30pm, Eskenazi Hospital contacted facility, stating that Resident #B was at the hospital, and inquiring if facility would re-admit him. Facility declined the offer to re-admit Resident #B.</li> </ul> <p><b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b></p> <ul style="list-style-type: none"> <li>· 10/15/15, 11:45pm, head count to ensure all residents present, completed by night shift nursing staff present.</li> <li>· 10/16/15, 12:00am, all residents with Roam Alerts were checked to ensure placement and</li> </ul>	

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	<p>not providing a Roam Guard device for a resident known to be an elopement risk, not maintaining awareness of his presence, and not promptly instituting a search and notifying management when he was first noted to be missing from the facility.</p> <p>In an interview with RN #2 on 10/20/15 at 9:30 A.M. She indicated she reported for work on 10/14/15 at 10:00 P.M., and was given report on Resident #B by LPN #1. RN #2 indicated she was not advised Resident #B had a diagnosis of dementia, or that he was an elopement risk. She indicated shortly after report Resident #B walked to the Rehab Unit door and stood there, but did not try to exit. She redirected him back to his room. She then reviewed Resident #B's record and noted a documented history of him "running away from home." She indicated she thought Resident #B needed a Roam Guard, but there was not one available on the medication cart on her unit. She indicated she did not try to locate one elsewhere, and did not notify anyone of the need. She indicated that at shift change on the morning of 10/15/15 she gave report to LPN #1 and advised her she believed Resident #B needed a Roam Guard based on history and wandering behavior. She indicated she did not tell anyone else of her concerns.</p>		<p>function by nursing staff on each unit.</p> <ul style="list-style-type: none"> <li>· 10/16/15, 12:00am, doors at the Main Entrance and the Rehab Unit Entrance were checked by nursing staff to ensure Roam alerts system working.</li> <li>· 10/16/15, 12:30am, elopement books at each unit and at the main entrance reception desk checked by nursing staff to ensure photos and Face Sheets of all residents determined to be at-risk from the Clinical Health Assessment are in place and correct.</li> <li>· 10/16/15, 8:30am, residents admitted/readmitted in last 60 days or that have a diagnosis of Alzheimer's had charts audited to ensure elopement assessment completed and, if indicated, resident had working Roam Alert, order to check placement and function, care plan and photo in elopement book. A total of 61 charts were reviewed. Of those 61 charts reviewed, 3 residents were identified by assessment as being at-risk for elopement. All 3 of these residents had a Roam Alert on their person, order for check of placement and function, care plan, and a photo in each of the elopement books.</li> <li>· 10/16/15, 4:00pm, all current residents' charts were audited. Audit completed.</li> </ul>	

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	<p>An interview with LPN #1 on 10/19/15 at 5:30 P.M. She indicated that on the morning of 10/15/15 RN #2, who had worked the night shift, indicated during report that Resident #B needed a Roam Guard, but one was not available. LPN #1 indicated she did not attempt to locate a Roam Guard. She indicated when she left the facility at 9:45 A.M., she was relieved by LPN #3, and that she told LPN #3 that Resident #B needed a Roam Guard at that time.</p> <p>LPN #3 was interviewed on 10/19/15 at 5:20 P.M. She indicated she had worked with Resident #B on 10/15/15, including administering his morning medications, and passing his breakfast and lunch trays. She indicated the resident was pleasant and cooperative and "very nice." She indicated Resident #B expressed no concerns or problems, and did not indicate he wanted to leave the facility. She indicated she saw him standing in his doorway observing the hall at 2:15 P.M., but that he did not leave his room. She indicated that was the last time she saw Resident #B.</p> <p>CNA #4 was interviewed on 10/20/15 at 2:15 P.M. She indicated she saw Resident #B in his room on the afternoon of 10/15/14, time uncertain, and that he</p>		<ul style="list-style-type: none"> <li>· 10/16/15, 5:00pm, all staff who worked the Rehab Unit during the stay of Resident #B were interviewed and disciplinary actions were given as indicated.</li> </ul> <p><b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b></p> <ul style="list-style-type: none"> <li>· 10/16/15, 6:00am, In-servicing to all staff present at the facility and prior to anyone working initiated by ED, AIT, DNS, ADNS. In-servicing completed for Nursing, Dietary, Housekeeping, Maintenance, Laundry, Front Office, Department Heads, Social Services, Activities, Therapy. This education continued through 10/20/15 with all employees in-serviced prior to working their next scheduled shift.</li> <li>· There are a total of 2 employees that have not yet been educated: 1 staff on LOA and not scheduled to return - messages have been left on her voicemail that a member of Nurse Management will be at the facility to in-service her prior to working first returned shift; 1 staff on Workman's Compensation Leave who is no longer on the schedule - messages have been left</li> </ul>	

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	<p>was quiet, sitting on his bed, and did not to her knowledge leave his room.</p> <p>LPN #5 was interviewed on 10/20/15 at 2:00 P.M. He indicated that on 10/15/15 he arrived 30 minutes late for his afternoon shift, and that LPN #3, who he was following, had left the unit to work on another unit, and he did not get report from her. He indicated that when he went to the unit where she was working to get the unit keys, LPN #3 told him "everything was ok" and gave him no other information. LPN #5 indicated that Resident #B's name "popped up" (on the computer) for 5:00 P.M. medications, but that he did not look for Resident #B, because, in his words, "other names popped up too, some were discharged." He indicated that when the night shift nurse, who came on at 10:00 P.M., began her daily census at "around 11:30 P.M." was when he was first aware Resident #B was missing. He indicated at that time he notified the Executive Director and began a building search for Resident #B.</p> <p>An undated facility policy titled "Elopement Guideline" received from the Director of Nursing Services on 10/17/15 at 1:00 P.M. indicated: "Definition: Elopement occurs when a resident leaves the premises or a safe area without authorization..."</p>		<p>on her voicemail that a member of Nurse Management will be at facility to in-service her if she returns.</p> <ul style="list-style-type: none"> <li>· All newly hired employees will be in-serviced through the New Employee General Orientation upon hire.</li> <li>· All new admissions will have a Clinical Health Status completed on admission. If the elopement risk triggers, nurse will proceed to Immediate Plan of Care (IPOC), which will be stapled to each Clinical Health Status by the Health Information Manager (if the resident does not trigger, the IPOC may be shredded).</li> <li>· Photos of residents will be taken upon admission. Camera will be kept in the East Unit Medication Room.</li> <li>· Staff in-serviced that Roam Alerts will be available on medication carts, available 24 hours a day. Roam Alert Audit Sheet placed in Narcotic Count Book, with shift-to-shift count and signature of nurse accepting cart that a Roam Alert is available. Staff in-serviced that if Roam Alerts are not available, staff is to contact ED or DNS.</li> <li>· Roam Alerts will be checked every shift to ensure placement and function by the charge nurse, with</li> </ul>	

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	<p>Initial Review: Upon admission, each resident is reviewed to establish elopement risk using the Clinical Status Form..."</p> <p>This Federal tag relates to Complaint IN00184761.</p> <p>3.1-28(a)</p>		<p>documentation on the Electronic Treatment Record (ETAR). Unit managers will review 5 x a week for 4 weeks and then weekly ongoing thereafter.</p> <ul style="list-style-type: none"> <li>· Maintenance staff will check and document functioning Roam Alert door alarms daily, and correct any malfunction immediately and notify ED of malfunction.</li> <li>· Weekend LOD (Leader on Duty) will check and document functioning Roam Alert door alarms on the weekend. LOD provided checklist of weekend duties and responsibilities, which includes checking function of Roam Alert door alarms, and availability of Roam Alerts on each medication cart. LOD will notify ED immediately of malfunction.</li> <li>· Elopement drills will be done on each shift monthly X 3 months, then on each shift quarterly thereafter with any trends reviewed in QAPI.</li> <li>· LPN #5 was suspended and received a disciplinary action and was terminated from employment on 10/20/15.</li> <li>· 10/23/15, a letter was sent to the Indiana Professional Licensing Board regarding the incident.</li> <li>· 10/26/15, CNA #4 not</li> </ul>	

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			<p>understanding elopement guideline and reporting procedure after in-servicing and elopement drills. CNA #4 employment terminated.</p> <ul style="list-style-type: none"> <li>· 11/4/15, facility main entrance door was secured so that it can not be opened without a code to enter or exit, thus making all facility doors require a code to use 24 hours per day, 7 days per week.</li> <li>· 11/5/15, ED, AIT, DNS in-serviced by Clinical Specialist Consultant on timely reporting of incidents to ISDH.</li> <li>· Maintenance staff and weekend LOD will continue to check all doors daily to ensure Roam Alert system and doors are locked daily.</li> </ul> <p><b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <ul style="list-style-type: none"> <li>· New admissions/readmissions will have medical records brought to morning clinical meeting and review to ensure all assessments completed and appropriate interventions have been implemented 5 x a week. Weekend Nurse Supervisor will</li> </ul>	

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			<p>perform task on weekends.</p> <ul style="list-style-type: none"> <li>· UM/Designee to review Roam Alert audit sheets 5 times a week to ensure a Roam Alert is available. DNS/Designee to verify audit completion and accuracy 5 x a week for 4 weeks, weekly thereafter on an ongoing basis.</li> <li>· Elopement Books from each unit and the front desk will be brought to clinical start-up 5 times a week, to ensure that any new admission or re-admission deemed at risk by the elopement assessment has picture and face sheet present in each of the Elopement Books (1 book at each nurse unit and 1 at the reception desk.)</li> <li>· Elopement drills will be done on each shift monthly X 3 months, quarterly thereafter with any trends reviewed in QAPI.</li> <li>· DNS/Designee will report findings of audits to monthly QAPI meetings for 6 months. Any patterns or trends will have an action plan written and interventions implemented.</li> </ul> <p><b>The systemic changes will be completed:</b></p>	

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F 0323 SS=J Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure supervision and safety interventions were implemented to prevent the elopement of one of three residents known to be an elopement risk. (Resident #B)</p> <p>The Immediate Jeopardy began on 10/14/15 at 7:10: P.M., when Resident #B was admitted to the facility and was identified as a known elopement risk. The Executive Director, Director of Nursing Services, Area Vice President, and Executive Director in Training were notified of the Immediate Jeopardy at 4:45 P.M., on 10/16/15. The Immediate Jeopardy was removed on 10/20/15 at 3:30 P.M., when the facility educated staff on elopement policy and procedure, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because the facility continued to provide reeducation and reassurance to</p>	F 0323	<p>November 6, 2015.</p> <p><b>F323</b></p> <p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <ul style="list-style-type: none"> <li>· 10/15/15, 11:45pm, ED notified by LPN#5 that Resident #B was not on his unit, the Rehab Unit.</li> <li>· 10/15/15, 11:45pm, facility search and grounds search at the 7145 East 21st street location initiated.</li> <li>· 10/16/15, 12:00am, ED arrived at facility and assisted staff with facility and grounds search.</li> <li>· 10/16/15, 12:00am, all family member phone numbers listed on Golden Living and Community Hospital Face Sheets were called by ED.</li> </ul>	11/06/2015
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	<p>residents and families regarding elopement.</p> <p>Findings include:</p> <p>On 10/16/15 at 10:27 A.M., the facility reported through the Indiana State Department of Health web based Survey Reporting System an initial report regarding the elopement of Resident #B, who was identified to be an elopement risk. The report indicated that on 10/15/15 at 11:45 P.M., Resident #B was identified as missing from the facility. The report indicated the Executive Director, Director of Nursing Services, and the Indianapolis Metropolitan Police were notified. A search was instituted, the resident's guardian (the Center for At Risk Elders) was contacted, and attempts were made to contact the resident's family.</p> <p>The record of Resident #B was reviewed on 10/16/15 at 12:00 P.M. Diagnoses, obtained from an Admission Record dated 10/14/15, included, but were not limited to, dementia with behavioral disturbance, Alzheimer's Disease, hypertension, angina, coronary artery disease, and chronic obstructive pulmonary disease.</p> <p>A timeline of events related to Resident</p>		<ul style="list-style-type: none"> <li>· 10/16/15, 12:45am, ED notified Indianapolis Metropolitan Police Department of the elopement of Resident #B - IMPD officer arrived at the facility.</li> <li>· 10/16/15, 12:52am, ED drove to 2914 English Avenue, which was the address listed on the Face Sheet of Resident #B.</li> <li>· 10/16/15, 2:15am, IMPD officer returned to facility, providing case #DP15120231.</li> <li>· 10/16/15, 2:45am, ED initiated in-servicing of all night shift nurses and C.N.A's present, on elopement guideline and reporting procedure.</li> <li>· 10/16/15, 5:45am, ED continued in-servicing with day shift nurses, CNA's, dietary staff, and housekeeping staff, with no staff working before being in-serviced.</li> <li>· 10/16/15, 7:30am, at daybreak, staff continued search of grounds and surrounding properties and neighborhood, businesses. Staff also drove to 2813 Meredith Avenue address found in Resident #B's hospital information.</li> <li>· 10/16/15, 9:10am, all family member phone numbers listed on Golden Living and Community Hospital Face Sheets called again by</li> </ul>	

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	<p>#B was provided by the Director of Nursing Services on 10/19/15 at 10:45 A.M., and indicated by her to be an accurate accounting of the events related to the elopement of Resident #B. Information in that timeline was obtained through interviews conducted by facility executive staff. It included, but was not limited to:</p> <p>10/14/15 7:15 P.M. "...(Resident #B) arrived at (the facility)...Diagnosis (sic) listed: HTN, COPD, Depression with behavioral disturbance, SOB, chest pain. Per assessment (Resident #B) was at risk for elopement. Roam guard, (an electronic device intended to be worn by residents who are at risk for elopement; if the resident approaches an external door, a warning sounds and the door locks. If the resident exits an open door, a facility wide alarm sounds) per (Facility) Elopement Guideline, should have been placed on (Resident #B) at that time....Per interview with (LPN #1) there was not a Roam Guard on the medication chart for the Rehab unit. When asked if she checked the other units medication chart she stated 'No.' When asked if she tried to contact anyone about where she could locate a Roam Guard, (LPN #1) stated. 'no.'"</p> <p>10/15/15 6:00 A.M. "During verbal report from night shift nurse (LPN #1) was told by (RN #2) that due to</p>		<p>ED.</p> <ul style="list-style-type: none"> <li>· 10/16/15, 9:10am, staff contacted taxi companies and bus companies to inquire about fares picked up outside facility.</li> <li>· 10/16/15, 9:10am, staff contacted Community Hospital East, Community Hospital North, Eskenazi Hospital, IU Methodist, St. Vincent Hospital, St. Francis Hospital, and Westview Hospital about possible admission of Resident #B.</li> <li>· 10/16/15, 9:15am, staff contacted Wheeler Mission, Good News Mission, and Salvation Army about Resident #B.</li> <li>· 10/16/15, 9:30am, staff again drove to English Avenue address, Meredith Avenue address, Bradbury Avenue address, and surrounding streets.</li> <li>· 10/16/15, 10:00am, ED notified Center for At-Risk Elders about elopement of Resident #B.</li> <li>· 10/16/15, 10:27am, ED submitted initial report to ISDH.</li> <li>· 10/16/15, 10:30am, ED spoke with IMPD detective assigned to elopement of Resident #B.</li> <li>· 10/16/15, 12:00pm, ED spoke with additional family members.</li> </ul>	

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	<p>confusion about wanting to see his wife, that the resident (Resident #B) should have a roam guard. (LPN #1) states she was on the unit until about 9:45 A.M. and was then relieved by (LPN #3), and during verbal report she told (LPN #3) that (Resident #B) should have a Roam Guard. When (LPN #1) was asked if she asked for a Roam Guard from the Unit Manager, DNS (Director of Nursing Services) or ED (Executive Director), all of which were present in the building (LPN #1) stated that she did not request the Roam Guard from any Department Manager."</p> <p>10/15/15 2:00 P.M. "...Stated she (CNA #4) never did see (Resident #B). That his bed was made and room appeared as though no one was occupying the room. (Resident #B's) name tag was on the outside door."</p> <p>10/15/15 2:25 P.M. "'I (LPN #3) was standing at the treatment cart...(Resident #B) was standing at the doorway of his room...I told him I would be there in a few minutes to finish his paperwork...' When asked if she did go to the room to complete it, (LPN #3) stated, 'no I got moved to ACU.'"</p> <p>10/15/15 2:30 P.M. "(LPN #5) Arrived to work, went to ACU to receive report from (LPN #3)...per (LPN #5) she (LPN #3) stated 'Everything was okay.'"</p> <p>10/15/15, between 2:00 P.M., and 4:00</p>		<ul style="list-style-type: none"> <li>· 10/16/15, 12:30pm, staff drove to Salvation Army, Good News Mission, Big Lots Plaza, Twin Aire Plaza, Kroger, McDonalds, English Avenue address, and surrounding streets.</li> <li>· 10/16/15, day and evening, staff continued drives to the Twin Aire Plaza area of English Avenue, Southeastern Avenue, and Rural Avenue. Staff continued telephone calls to family members.</li> <li>· 10/17/15, all day and evening, staff continued drives to the Twin Aire Plaza area of English Avenue, Southeastern Avenue, and Rural Avenue. Staff continued telephone calls to family members.</li> <li>· 10/17/15, 10:30am, ED learned that the Twin Aire Plaza Kroger Customer Service Manager posted on social media that she saw and spoke with Resident #B. ED drove to Kroger and interviewed Manager, who stated that she saw Resident #B on 10/15/15 at about 5pm, and he informed her he rode the city bus to Twin Aire Plaza at that time.</li> <li>· 10/17/15, 11:15am, ED drove to other Twin Aire Plaza businesses and 3834 Spann address provided by Kroger Manager, as well as homeless tent areas, World Mission Thrift Store, Christian Park, and New Crown Cemetery.</li> </ul>				

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	<p>P.M., from facility interviews with residents #J and #K: "Both these residents were on the porch outside the Rehab unit and noted the resident walking across the parking lot. Both noted he did not exit the rehab unit door, but appeared as though he had exited the main door. Resident K stated 'I yelled at him...' but he did not answer...Both stated they never saw him again and both gentlemen stated they did not tell anyone about this..."</p> <p>10/15/15 3:00 P.M. "(LPN #5) Did not administer (named medications) as ordered, when asked why he did not question the location of the resident, (LPN #5) stated, '(CNA #4) said he was gone out of the building with family.' Upon interview with both (CNA #4) and ((LPN #5), she (LPN #4) maintains she never made that statement and (LPN #5) acknowledges he may have misunderstood her. 'CNA #4) is at times difficult to understand due to English being her second language."</p> <p>10/15/15 11:30 P.M. "He (LPN #5) stated that his Unit Manager had left him some paperwork that needed to be done and a part of that was the paperwork on (Resident #B), he stated it was at that time he questioned where the resident was and why he had not 'returned' to the facility, as he thought he heard (CNA #4) say he was out with family."</p>		<ul style="list-style-type: none"> <li>· 10/18/15 – 10/24/15, staff continued daily drives to English Avenue, Southeastern Avenue, Rural Avenue area, Twin Aire Plaza area, Kroger, McDonalds, Big Lots Plaza, New Crown Cemetery, and missions. Staff continued daily calls to family members.</li> <li>· 10/24/15, 4:12pm, ED contacted by Twin Aire Plaza Kroger Customer Service Manager that Resident #B was in store, and 911 called.</li> <li>· 10/24/15, 6:45pm, ED contacted by IMPD officer that Resident #B had been located, detained, checked medically by EMT's at scene. ED informed officer of elopement, medical diagnoses of Resident #B, Missing Persons Report, IMPD investigation, and the need for Resident #B to be taken to a hospital or returned to facility. Officer stated that Resident #B did not appear disheveled or ill, seemed to be oriented and spoke clearly, and that Resident #B did not want to go to hospital or to facility. Officer stated he could not legally detain Resident #B since he seemed oriented and was responding appropriately. ED informed officer that the Center for At-Risk Elders was the guardian for Resident #B and they had placed him in the care of the facility.</li> <li>· 10/24/15, 7:15pm, ED</li> </ul>	

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	<p>10/15/15 11:45 P.M. "(LPN #5) Notified ED (Executive Director) That (Resident #B) was not in the facility. ED instructed (LPN #5) to initiate a search of the unit while ED awaited results. (LPN #5) returned to telephone and informed ED that resident was not on the unit. ED then instructed that he would be in the facility within 15 minutes and to initiate an ALL facility search."</p> <p>10/16/15 12:00 A.M. " ED arrived at facility and initiated an external premises search..."</p> <p>10/16/15 12:45 A.M. "ED notified Indianapolis Metropolitan Police Department. (Officer) arrived at facility to take report."</p> <p>10/16/15 12:52 A.M. "Notified Area Vice President...in route to (addresses from admission records.)"</p> <p>10/16/15 2:15 A.M. "(Officer) returned to facility, provided case number...stated he had discussed the report with his sergeant, and that a detective would be contact ED." (sic)</p> <p>The Executive Director (ED) and Area Vice President were interviewed on 10/16/15 at 3:00 P.M. The ED indicated Resident #B had eloped from the facility sometime on the afternoon of 10/15/15, and that he remained missing. The ED indicated that admission documentation indicated Resident #B had a diagnosis of</p>		<p>contacted by the Center for At-Risk Elders Executive Director that Resident #B was released to the care of his grandson.</p> <ul style="list-style-type: none"> <li>· 11/6/15, 12:30pm, Eskenazi Hospital contacted facility, stating that Resident #B was at the hospital, and inquiring if facility would re-admit him. Facility declined the offer to re-admit Resident #B.</li> </ul> <p><b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b></p> <ul style="list-style-type: none"> <li>· 10/15/15, 11:45pm, head count to ensure all residents present, completed by night shift nursing staff present.</li> <li>· 10/16/15, 12:00am, all residents with Roam Alerts were checked to ensure placement and function by nursing staff on each unit.</li> <li>· 10/16/15, 12:00am, doors at the Main Entrance and the Rehab Unit Entrance were checked by nursing staff to ensure Roam alerts system working.</li> <li>· 10/16/15, 12:30am,</li> </ul>	

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	<p>dementia and was an identified elopement risk. The ED indicated both family and police had indicated Resident #B had an established pattern of disappearing and fraternizing with the homeless and street people of the Near East Side of Indianapolis, and he would typically be gone until his resources ran out. The ED indicated staff had not followed facility policy and procedure in not providing a Roam Guard device for a resident known to be an elopement risk, not maintaining awareness of his presence, and not promptly instituting a search and notifying management when he was first noted to be missing from the facility.</p> <p>In an interview on 10/20/15 at 9:30 A.M., with RN #2, indicated she reported for work on 10/14/15 at 10:00 P.M. and was given report on Resident #B by LPN #1. RN #2 indicated she was not advised Resident #B had a diagnosis of dementia, or that he was an elopement risk. She indicated shortly after report Resident #B walked to the Rehab Unit door and stood there, but did not try to exit. She redirected him back to his room. She then reviewed Resident #B's record and noted a documented history of him "running away from home." She indicated she thought Resident #B needed a Roam Guard, but there was not one available on</p>		<p>elopement books at each unit and at the main entrance reception desk checked by nursing staff to ensure photos and Face Sheets of all residents determined to be at-risk from the Clinical Health Assessment are in place and correct.</p> <ul style="list-style-type: none"> <li>· 10/16/15, 8:30am, residents admitted/readmitted in last 60 days or that have a diagnosis of Alzheimer's had charts audited to ensure elopement assessment completed and, if indicated, resident had working Roam Alert, order to check placement and function, care plan and photo in elopement book. A total of 61 charts were reviewed. Of those 61 charts reviewed, 3 residents were identified by assessment as being at-risk for elopement. All 3 of these residents had a Roam Alert on their person, order for check of placement and function, care plan, and a photo in each of the elopement books.</li> <li>· 10/16/15, 4:00pm, all current residents' charts were audited. Audit completed.</li> <li>· 10/16/15, 5:00pm, all staff who worked the Rehab Unit during the stay of Resident #B were interviewed and disciplinary actions were given as indicated.</li> </ul> <p><b>The measures put into place and</b></p>	

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	<p>the medication cart on her unit. She indicated she did not try to locate one elsewhere, and did not notify anyone of the need. She indicated that at shift change on the morning of 10/15/15 she gave report to LPN #1 and advised her she believed Resident #B needed a Roam Guard based on history and wandering behavior. She indicated she did not tell anyone else of her concerns.</p> <p>LPN #1 was interviewed on 10/19/15 at 5:30 P.M. She indicated that on the morning of 10/15/15 RN #2, who had worked the night shift, indicated during report that Resident #B needed a Roam Guard, but one was not available. LPN #1 indicated she did not attempt to locate a Roam Guard. She indicated when she left the facility at 9:45 A.M. she was relieved by LPN #3, and that she told LPN #3 that Resident #B needed a Roam Guard at that time.</p> <p>LPN #3 was interviewed on 10/19/15 at 5:20 P.M. She indicated she had worked with Resident #B on 10/15/15, including administering his morning medications, and passing his breakfast and lunch trays. She indicated the resident was pleasant and cooperative and "very nice." She indicated Resident #B expressed no concerns or problems, and did not indicate he wanted to leave the facility.</p>		<p><b>the systemic changes made to ensure that this deficient practice does not recur are as follows:</b></p> <ul style="list-style-type: none"> <li>· 10/16/15, 6:00am, In-servicing to all staff present at the facility and prior to anyone working initiated by ED, AIT, DNS, ADNS. In-servicing completed for Nursing, Dietary, Housekeeping, Maintenance, Laundry, Front Office, Department Heads, Social Services, Activities, Therapy. This education continued through 10/20/15 with all employees in-serviced prior to working their next scheduled shift.</li> <li>· There are a total of 2 employees that have not yet been educated: 1 staff on LOA and not scheduled to return - messages have been left on her voicemail that a member of Nurse Management will be at the facility to in-service her prior to working first returned shift; 1 staff on Workman's Compensation Leave who is no longer on the schedule - messages have been left on her voicemail that a member of Nurse Management will be at facility to in-service her if she returns.</li> <li>· All newly hired employees will be in-serviced through the New Employee General Orientation upon hire.</li> </ul>	

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	<p>She indicated she saw him standing in his doorway observing the hall at 2:15 P.M., but that he did not leave his room. She indicated that was the last time she saw Resident #B.</p> <p>CNA #4 was interviewed on 10/20/15 at 2:15 P.M. She indicated she saw Resident #B in his room on the afternoon of 10/15/14, time uncertain, and that he was quiet, sitting on his bed, and did not to her knowledge leave his room.</p> <p>LPN #5 was interviewed on 10/20/15 at 2:00 P.M. He indicated that on 10/15/15 he arrived 30 minutes late for his afternoon shift, and that LPN #3, who he was following, had left the unit to work on another unit, and he did not get report from her. He indicated that when he went to the unit where she was working to get the unit keys, LPN #3 told him "everything was ok" and gave him no other information. LPN #5 indicated that Resident #B's name "popped up" (on the computer) for 5:00 P.M. medications, but that he did not look for Resident #B, because, in his words, "other names popped up too, some were discharged." He indicated that when the night shift nurse, who came on at 10:00 P.M., began her daily census at "around 11:30 P.M." was when he was first aware Resident #B was missing. He indicated at that time he</p>		<ul style="list-style-type: none"> <li>· All new admissions will have a Clinical Health Status completed on admission. If the elopement risk triggers, nurse will proceed to Immediate Plan of Care (IPOC), which will be stapled to each Clinical Health Status by the Health Information Manager (if the resident does not trigger, the IPOC may be shredded).</li> <li>· Photos of residents will be taken upon admission. Camera will be kept in the East Unit Medication Room.</li> <li>· Staff in-serviced that Roam Alerts will be available on medication carts, available 24 hours a day. Roam Alert Audit Sheet placed in Narcotic Count Book, with shift-to-shift count and signature of nurse accepting cart that a Roam Alert is available. Staff in-serviced that if Roam Alerts are not available, staff is to contact ED or DNS.</li> <li>· Roam Alerts will be checked every shift to ensure placement and function by the charge nurse, with documentation on the Electronic Treatment Record (ETAR). Unit managers will review 5 x a week for 4 weeks and then weekly ongoing thereafter.</li> <li>· Maintenance staff will check and document functioning Roam Alert door alarms daily, and correct any malfunction immediately and</li> </ul>	

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	<p>notified the Executive Director and began a building search for Resident #B.</p> <p>An undated facility policy titled "Elopement Guideline" received from the Director of Nursing Services on 10/17/15 at 1:00 P.M. indicated:</p> <p>"Definition: Elopement occurs when a resident leaves the premises or a safe area without authorization...</p> <p>Initial Review: Upon admission, each resident is reviewed to establish elopement risk using the Clinical Status Form..."</p> <p>The Immediate Jeopardy that began on 10/14/15 was removed on 10/20/15 at 3:30 P.M., when the facility educated staff on elopement policy and procedure, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because the facility continued to provide reeducation and reassurance to residents and families regarding elopement.</p> <p>This Federal tag relates to Complaint IN00184761.</p> <p>3.1-45(a)(2)</p>		<p>notify ED of malfunction.</p> <ul style="list-style-type: none"> <li>· Weekend LOD (Leader on Duty) will check and document functioning Roam Alert door alarms on the weekend. LOD provided checklist of weekend duties and responsibilities, which includes checking function of Roam Alert door alarms, and availability of Roam Alerts on each medication cart. LOD will notify ED immediately of malfunction.</li> <li>· Elopement drills will be done on each shift monthly X 3 months, then on each shift quarterly thereafter with any trends reviewed in QAPI.</li> <li>· LPN #5 was suspended and received a disciplinary action and was terminated from employment on 10/20/15.</li> <li>· 10/23/15, a letter was sent to the Indiana Professional Licensing Board regarding the incident.</li> <li>· 10/26/15, CNA #4 not understanding elopement guideline and reporting procedure after in-servicing and elopement drills. CNA #4 employment terminated.</li> <li>· 11/4/15, facility main entrance door was secured so that it can not be opened without a code to enter or exit, thus making all facility doors require a code to use</li> </ul>	

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			<p>24 hours per day, 7 days per week.</p> <ul style="list-style-type: none"> <li>11/5/15, ED, AIT, DNS in-serviced by Clinical Specialist Consultant on timely reporting of incidents to ISDH.</li> <li>Maintenance staff and weekend LOD will continue to check all doors daily to ensure Roam Alert system and doors are locked daily.</li> </ul> <p><b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <ul style="list-style-type: none"> <li>New admissions/readmissions will have medical records brought to morning clinical meeting and review to ensure all assessments completed and appropriate interventions have been implemented 5 x a week. Weekend Nurse Supervisor will perform task on weekends.</li> <li>UM/Designee to review Roam Alert audit sheets 5 times a week to ensure a Roam Alert is available. DNS/Designee to verify audit completion and accuracy 5 x a week for 4 weeks, weekly thereafter on an</li> </ul>	

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			<p>ongoing basis.</p> <ul style="list-style-type: none"> <li>· Elopement Books from each unit and the front desk will be brought to clinical start-up 5 times a week, to ensure that any new admission or re-admission deemed at risk by the elopement assessment has picture and face sheet present in each of the Elopement Books (1 book at each nurse unit and 1 at the reception desk.)</li> <li>· Elopement drills will be done on each shift monthly X 3 months, quarterly thereafter with any trends reviewed in QAPI.</li> <li>· DNS/Designee will report findings of audits to monthly QAPI meetings for 6 months. Any patterns or trends will have an action plan written and interventions implemented.</li> </ul> <p><b>The systemic changes will be completed:</b></p> <p>November 6, 2015.</p>	