

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 12/18/2014
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NAME OF PROVIDER OR SUPPLIER  COUNTRY CHARM VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227
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R000000	<p>This visit was for the Investigation of Complaint IN00160847.</p> <p>Complaint IN00160847 - Substantiated. State deficiencies related to the allegations are cited at R006, R052, R090, R148, R214, and R217.</p> <p>Survey date: 12/18/2014</p> <p>Facility number: 003283 Provider number: 003283 AIM number: N/A</p> <p>Survey team: Marcy Smith, RN - TC</p> <p>Census bed type: Residential: 55 Total: 55</p> <p>Census Payor Type: Medicaid: 37 Total: 37</p> <p>Residential sample: 3</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on December 21, 2014; by Kimberly Perigo, RN.</p>	R000000	<p>This plan of correction is submitted as required under either or both State and Federal law. The submission of this Plan of Correction does not constitute an admission of fault or liability to the government entity or any third party, on the part of Country Charm Village, as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis and the Facility reserves its right to object to the admission of this Statement of Deficiency or the Plan of Correction under any other theory of law. the facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director, attorney, or shareholder of the facility or affiliated companies.</p>	
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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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R000006	<p>410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>Based on record review and interview, the facility failed to ensure a resident was considered for discharge or placement in a Memory Care unit for his personal safety as indicated by facility policy, in regard to multiple exit-seeking behaviors and 2 elopements, for 1 of 3 residents reviewed scope of residential care. (Resident #A)</p> <p>Findings include:</p>	R000006	<p>1. On 12/18/14 the resident identified in this deficiency citation was assessed and accepted for admission by another senior living community with memory care unit. The resident was discharge to that facility on 12/19/14.2. Facility will identify other residents having the potential to be affected as follows:The facility will review all resident records and determine if other residents may be affected by the alleged deficient practice. Any residents, including new</p>	01/30/2015
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	<p>On 12/8/14 at 10:10 a.m., the Executive Director provided a policy dated June, 2009, titled, "Admission and Discharge Criteria for Residential Care, and indicated it was the policy currently used by the facility. The policy indicated, "...when it is determined that a resident is no longer capable of functioning in Residential Care, or when said resident impinges upon the rights or quality of life of other residents, discharge/transfer proceedings may be initiated... Resident must be discharged if the resident: is a danger to the resident or others..."</p> <p>The clinical record of Resident #A was reviewed 12/18/14 at 10:50 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease.</p> <p>A nurse's note, dated 8/19/14 at 8:20 p.m., indicated, "Res[ident] has had [increased] in behaviors and agitation. [increased] confusion."</p> <p>A nurse's note on 9/28/14 at 12:00 a.m., indicated Resident #A had left the facility without staff knowledge and was found by the police at a restaurant down the highway. The police indicated to the facility he was, "confused and disoriented."</p> <p>A physician's progress note, dated</p>		<p>prospective residents identified will be evaluated for wandering and exit seeking behavior. Results will be reviewed by the DON. appropriate interventions will be initiated up to and including discharge from the facility if necessary. If a resident is determined able to remain within the Assisted Living facility with appropriate interventions, the resident will be re-evaluated within 90 days from the initial evaluation.3. Measures put in place to ensure that the alleged deficient practice does not recur are as follows: All prospective residents will be given a preliminary assessment to determine exit seeking behavior and risk for wandering If a resident is determined able to remain within the Assisted Living facility with appropriate interventions, the resident will be re-evaluated within 90 days from the initial evaluation. Additional assessments will be completed quarterly and upon a significant change of condition.4. The Executive Director and DON will review results of all current resident assessments for an 30 day period. All future assessments will be reviewed by the DON or designee.5. Systemic changes will be completed by January 30, 2015.</p>				

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	<p>9/30/14, indicated, "Eloped on 9/28/14, walked to restaurant &gt;1 mile away unsupervised, was returned to facility by [police]."</p> <p>A nurse's note on 10/28/14 at 4:45 a.m., indicated, "Res[ident] tried to exit through the front entrance x 2 this shift, res[ident] then began to wander around the facility to each door trying to exit..."</p> <p>A nurse's note dated 10/29/14 at 9:00 p.m., indicated, "Res[ident] exit seeking. put on 15 min[ute] checks."</p> <p>A nurse's note dated 10/30/14 at at 7:40 p.m., indicated, "Res[ident] exit seeking. Put on 15 min[ute] checks."</p> <p>A nurses's note dated 11/30/14 at 7:00 p.m., indicated resident had not come down for dinner, and when a search was initiated, staff was unable to locate resident. Police located resident at a restaurant down the highway from the facility around 8:00 p.m.</p> <p>No documentation was found in Resident #A's record regarding consideration of discharge or transfer to a secured unit, for his own safety, between 8/19/14 and 12/1/14.</p> <p>A physician's progress note, dated</p>						

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	<p>12/1/14, indicated, "Staff reports elopement x 2 hrs [hours] to [name of local restaurant], no injuries. Staff concerned [with] pt [patient] safety as he has had multiple elopements and attempts. Res[ident] walked along side of busy road unassisted...Recommend placement in suitable dementia care locked unit for pt. safety. Notified DON [Director of Nursing] and Executive Director."</p> <p>A nurse's note, dated 12/2/14 at 9:25 p.m., indicated, "Res[ident] in front lobby upon arrival of shift @ 2 pm...confused wandering behavior most of shift...[Nurse Practitioner] in fac[ility]...recommendations to placement in suitable dementia care unit [related] to pt [patient] safety - progressive dementia [with] agitation, wandering, elopement..."</p> <p>Nurse's note 12/2/14 at 10:00 p.m., "Spoke with son...son is expressing interest in placing in different facility and has been communicating interest to [Director of Nursing]."</p> <p>A nurse's note dated 12/9/14, no time, indicated, "[Medical doctor] in facility [with new orders] to move to locked unit or discharge from facility...family [son] notified - son request [Director of Nursing] phone him tomorrow. Writer</p>			

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R000052	<p>notified [Director of Nursing] of said request."</p> <p>Resident #A remained in the facility, not on the Memory Care unit, from 12/1/14, when the physician recommended placement on locked unit for safety, until 12/18/14, at 9:00 a.m., when the Executive Director indicated someone from a different residential facility with a secured unit, was in the building to evaluate Resident #A for transfer/discharge.</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. Based on observation, record review, and interview, the facility failed to ensure a confused resident was free from neglect, in regard to having his safety needs met through evaluation, implementation of</p>	R000052	1. Resedent A was discharged on 12/19/14 to another senior living community with a memory care unit. 2. the facility will review all resident records and determine if other residents may be affected by the alleged deficient practice.	01/30/2015

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	<p>interventions, and building maintenance, for 1 of 3 residents reviewed for having their safety needs met. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record of Resident #A was reviewed 12/18/14 at 10:50 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease.</p> <p>1. An Assessment and Service Plan for Resident #A, dated 7/14/14, indicated his, "Judgement and memory are generally good. Needs monitoring and guidance and occasional redirection." The spaces next to "wandering" and "exit seeking" were not checked.</p> <p>A nurse's note on 9/28/14 at 12:00 a.m., indicated Resident #A had left the facility without staff knowledge and was found by the police at a restaurant down the highway. The police indicated to the facility he was, "confused and disoriented."</p> <p>A nurse's note on 10/28/14 at 4:45 a.m., indicated, "Res[ident] tried to exit through the front entrance x 2 this shift, res[ident] then began to wander around the facility to each door trying to exit..."</p> <p>A nurse's note dated 10/30/14 at at 7:40</p>		<p>Any residents identified will be evaluated for wandering and exit seeking behavior. Results will be reviewed by the DON.</p> <p>Appropriate interventions will be initiated up to and including discharge from the facility if necessary. If a resident is determined able to remain within the Assisted Living facility with appropriate interventiions, the resident will be re-evaluated with in 90 days from the initial evaluation. 3. Measures put in place will be as follows: An initial preliminary assessment will be completed to determine the resident is able to safely remain within the facility. If a resident is determined able to remain within the Assisted Living facility with appropriate interventions, the resident will be re-evaluated within 90 days from the initial evaluation. A second assessment will be completed within 90 days of admission for all residents who exhibit exit seeking and wandering behaviors. Additional assessments will be completed upon a significant change in condition and quarterly assessments with interventions completed for any resident who exhibits exit seeking and wandering behaviors. the front door is locked and remains locked. The facility will continue to monitoe front door entry locks as well as other exit/ entry doors. Maintenance shall check door locks daily for four weeks</p>				

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	<p>p.m., indicated, "Res[ident] exit seeking. Put on 15 min[ute] checks."</p> <p>A nurses's note dated 11/30/14 at 7:00 p.m., indicated resident had not come down for dinner, and when a search was initiated, staff was unable to locate resident. Police located resident at a restaurant down the highway from the facility around 8:00 p.m.</p> <p>Another evaluation by a licensed nurse, with services to be provided by the facility, was not done until 12/12/14. This assessment indicated Resident #A was confused, wanders day and night, agitated and knows person only, "states he wants to leave and go to Mississippi and Chicago, ...Judgment and memory is usually poor. Needs complete supervision. ... Attempts to leave facility in unsafe manner..."</p> <p>On 12/18/14 at 1:20 p.m., the Director of Nursing indicated a resident should be reevaluated if a significant change in behavior occurred.</p> <p>On 12/18/14, at 1:30 p.m., the Executive Director provided an undated policy, titled, "Elopement Assessment Policy and Procedures," and indicated it was the policy currently used by the facility. The policy indicated, "...Certain assisted</p>		<p>Maintenance shall check door locks weekly for one month Maintenance will check door locks monthly. This will continue as an ongoing door lock check The systemic change will be implemented if the exit door locks fail to function will be as follows:</p> <p>If the door is found to malfunction the ED, maintenance person, and/or designee will implement 15 minute resident checks on any current residents that may be at risk for elopement. Current staff will be in serviced by January 30, 2015 regarding this procedure.</p> <p>4. The DON will be responsible for completion of assesments and the Executive Director will monitor compliance for assessments and doors. 5. LThe date for systemic changes will be completed by January 30, 2015.</p>	

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	<p>living residents will be assessed for elopement risk on admission, readmission after hospitalization, presentation of exit seeking behavior including but not limited to...actual elopement, at the time of a scheduled assessment if necessary, and/or as condition changes that would warrant an elopement assessment."</p> <p>2. An Assessment and Service Plan for Resident #A, dated 7/14/14, indicated his, "Judgement and memory are generally good." The service/intervention was, "Needs monitoring and guidance and occasional redirection." The spaces next to "wandering" and "exit seeking" were not checked.</p> <p>A nurse's note on 9/28/14 at 12:00 a.m., indicated Resident #A had left the facility without staff knowledge and was found by the police at a restaurant down the highway. The police indicated to the facility he was, "confused and disoriented."</p> <p>A nurse's note on 10/28/14 at 4:45 a.m., indicated, "Res[ident] tried to exit through the front entrance x 2 this shift, res[ident] then began to wander around the facility to each door trying to exit..."</p>			

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	<p>A nurse's note dated 10/30/14 at at 7:40 p.m., indicated, "Res[ident] exit seeking. Put on 15 min[ute] checks."</p> <p>A nurses's note dated 11/30/14 at 7:00 p.m., indicated resident had not come down for dinner, and when a search was initiated, staff was unable to locate resident. Police located resident at a restaurant down the highway from the facility around 8:00 p.m.</p> <p>Resident #A's service plan was not updated until 12/11/14, with interventions and services to be provided for exit seeking and/or elopement behavior. One intervention was, "...will be cued and redirected as needed...Interventions are most of the time ineffective..."</p> <p>During observations on 12/18/14, at 9:00 a.m., 10:45 a.m., 11:03 a.m., and 1:15 p.m., Resident #A was sitting in lobby near front door, or wandering around lobby/front door area.</p> <p>3. A nurses's note, dated 9/28/14 at 12:00 a.m., indicated the police had called the facility to report they had a resident, "confused and disoriented," in their custody who was found at a local restaurant down the street from the facility.</p>			

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	<p>A physician's progress note, dated 9/30/14, indicated, "Eloped on 9/28/14. walked to restaurant &gt;1 mile away, unsupervised, was returned to facility by [police]. No injuries. Is now on 15 min[ute] checks d/t [due to] problems [with] facilities front door locks...Attempted to discuss elopement [with] pt. [patient], pt. reports he walked away and ate but did not seem to understand the risks associated with leaving facility unaccompanied. Res[ident] refused to answer or said I don't remember when questioned about his location, year, season, month, etc."</p> <p>Review of a [name of local company] invoice, dated 10/9/14, indicated a service request was created on 9/24/14, and completed on 10/8/14. the invoice described the repair work as, "... front entry mag door hold replacement per approved quote."</p> <p>In an interview with the Executive Director, on 12/18/14 at 1:00 p.m., she indicated when Resident #A eloped on 9/28/14 at 12:00 a.m., it was during the time when the front doors were not locking. She indicated hourly checks had been done on all the residents on this date, from 12:00 a.m. through 6:00 a.m., because of the malfunctioning doors.</p>			
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	<p>She indicated on the days the front doors would not lock, the staff tried to keep watch and made frequent checks on residents.</p> <p>4. On 12/18/14, at 1:30 p.m., the Executive Director provided an undated policy, titled, "Elopement Assessment Policy and Procedures," and indicated it was the policy currently used by the facility. The policy indicated, "If it is determined that the resident may be a risk for elopement, immediate interventions should be put into place..."</p> <p>This same policy indicated if a resident was determined to be a risk for elopement, a "Wandering Resident Information Sheet" should be completed. This should include a photo. The sheet should be placed in the "Resident Wandering Binder in the designated area for quick staff access."</p> <p>In an interview with the Executive Director on 12/18/14 at 3:30 p.m., she indicated she did not know if the facility had a Resident Wandering Binder. In an interview with the Director of Nursing on 12/18/14 at 3:35 p.m., he indicated he did not know about a Resident Wandering Binder. At 3:45 p.m., 2 nurses in the Clinic indicated they thought there was a binder but they weren't sure where it was.</p>			

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R000090	<p>At 3:50 p.m., the binder, which had been in the Memory Care unit, was provided. Residents #A's information and picture was not in the binder. The Executive Director indicated, at that time, the binder was not current.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent</p>			

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	<p>by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to notify the Indiana State Department of Health within 24 hours regarding a resident elopement, for</p>	R000090	<p>1. The corrective action that has been accomplished for Resident A was discharged to another senior living center with a memory care unit.2. The facility</p>	01/30/2015

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	<p>1 of 2 elopements reviewed for notification. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record of Resident #A was reviewed on 12/18/14 at 10:50 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease.</p> <p>On 11/30/14, Resident #A's record indicated, he was observed to be missing from the facility around 5:30 p.m. The record indicated the police found the resident around 8:00 p.m. that same evening.</p> <p>An Incident Report Form was sent to the Indiana State Department of Health (ISDH) regarding this occurrence. The Executive Director (ED) provided date and time of submission of report by showing when the email containing the report of the incident was sent to ISDH. The date and time indicated by the ED's email was 9/2/14 at 9:43 a.m. On 12/18/14 at The ED indicated she was aware reports of unusual occurrences needed to be sent to the state in 24 hours or less, that was the policy followed by the facility. She indicated she had been very busy the day after the occurrence and just hadn't had time to submit the report until 9/2/14.</p>		<p>shall review each resident's record and determine all residents could be affected by the alleged deficient practice and all employees will be trained how to report similar incidents to the DON and Executive Director for reporting to the ISDOH. 3. The measures that will be put into place and the systemic changes the facility will make are as follows: The Executive Director shall inservice and re-educate all staff regarding the reporting requirements associated with reportable unusual occurrences. This topic has been added to the new employee orientation program. The systemic change that will be implemented is staff inservice training for new and current employees and a post test given on the state's reportable guidelines. 4. The Executive Director or designee will report any reportable incidents to the ISDOH within 24 hours of knowledge of occurrence. 5. The date the systemic changes will be January 30, 2015.</p>				

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R000148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on record review and interview, the facility failed to ensure the front doors providing entrance to and exit from the facility were maintained in good working order, which allowed a confused resident to leave without knowledge of the staff. (Resident #A)</p> <p>Findings include:</p> <p>The clinical record of Resident #A was reviewed on 12/18/14 at 10:50 a.m.</p>	R000148	<p>1. The corrective action that has been accomplished was the front door is locked and remains locked. 2. The facility will continue to monitor front door entry locks as well as other exit/entry doors. 3. The measures that will be put into place and systemic changes the facility will make to ensure the alleged deficient practice does not recur shall include the following: Maintenance shall check door locks daily for four weeks. Maintenance shall check</p>	01/30/2015
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	<p>Diagnoses for the resident included, but were not limited to, Alzheimer's disease.</p> <p>A nurses's note, dated 9/28/14 at 12:00 a.m., indicated the police had called the facility to report they had a resident, "confused and disoriented," in their custody, who was found at a local restaurant down the street from the facility.</p> <p>A physician's progress note, dated 9/30/14, indicated, "Eloped on 9/28/14. walked to restaurant &gt;1 mile away, unsupervised, was returned to facility by [police]. No injuries. Is now on 15 min[ute] checks d/t [due to] problems [with] facilities front door locks...Attempted to discuss elopement [with] pt. [patient], pt. reports he walked away and ate but did not seem to understand the risks associated with leaving facility unaccompanied. Res[ident] refused to answer or said I don't remember when questioned about his location, year, season, month, etc."</p> <p>Review of a [name of local company] invoice, dated 10/9/14, indicated a service request was created on 9/24/14, and completed on 10/8/14. the invoice described the repair work as, "... front entry mag door hold replacement per approved quote."</p>		<p>door locks weekly for one month. Maintenance will check door locks monthly. This will continue as an ongoing door lock check</p> <p>The systemic change will be implemented if the exit door locks fail to function will be as follows:</p> <p>If the door is found to malfunction the ED, maintenance person, and/or designee will implement 15 minute resident checks on any current residents that may be at risk for elopement. Current staff will be in serviced by January 30, 2015 regarding this procedure.</p> <p>4. the corrective action will be the responsibility of the maintenance person and the Executive Directive will monitor monthly. 5. The date the systemic changes will be completed by January 30, 2015.</p>				

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R000214	<p>In an interview with the Executive Director, on 12/18/14 at 1:00 p.m., she indicated when Resident #A eloped on 9/28/14 at 12:00 a.m., it was during the time when the front doors were not locking. She indicated hourly checks had been done on all the residents on this date, from 12:00 a.m. through 6:00 a.m., because of the malfunctioning doors. She indicated on the days the front doors would not lock, the staff tried to keep watch and made frequent checks on residents.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to ensure an evaluation by a licensed nurse was initiated after a known substantial change in a resident's behavior. (Resident #A)</p> <p>Findings include:</p>	R000214	<p>1. the corrective action that will be accomplished for Resident A was discharged to another senior living facility with a memory care unit on 12/19/14. 2. The facility will review each resident's records and determine all residents found to have exit seeking and wandering</p>	01/30/2015

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	<p>The clinical record of Resident #A was reviewed 12/18/14 at 10:50 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease.</p> <p>An Assessment and Service Plan for Resident #A, dated 7/14/14, indicated his, "Judgement and memory are generally good. Needs monitoring and guidance and occasional redirection." The spaces next to "wandering" and "exit seeking" were not checked.</p> <p>A nurse's note on 9/28/14 at 12:00 a.m., indicated Resident #A had left the facility without staff knowledge and was found by the police at a restaurant down the highway. The police indicated to the facility he was, "confused and disoriented."</p> <p>A nurse's note on 10/28/14 at 4:45 a.m., indicated, "Res[ident] tried to exit through the front entrance x 2 this shift, res[ident] then began to wander around the facility to each door trying to exit..."</p> <p>A nurse's note dated 10/30/14 at 7:40 p.m., indicated, "Res[ident] exit seeking. Put on 15 min[ute] checks."</p> <p>A nurses's note dated 11/30/14 at 7:00 p.m., indicated resident had not come down for dinner, and when a search was</p>		<p>behaviors. Any residents identified will be evaluated for wandering and exit seeking behavior. Results will be reviewed by the DON. Appropriate interventions will be initiated up to and including discharge from the facility if necessary. If a resident is determined able to remain within the Assisted Living facility with appropriate interventions, the resident will be re-evaluated within 90 days from the initial evaluation. 3. Measures put in place will be as follows: An initial preliminary assessment will be completed to determine at risk for elopement. A second assessment will be completed within 90 days of admission for all residents who exhibit exit seeking and wandering behaviors. If a resident is determined able to remain within the Assisted Living facility with appropriate interventions, the resident will be re-evaluated within 90 days from the initial assessment. Additional assessments will be completed upon a significant change in condition and quarterly assessments with interventions completed for any resident who exhibit exit seeking and wandering behaviors. 4. The DON will be responsible for completion of assessments and the Executive Director will monitor compliance. 5. The date for systemic changes will be completed by January 30, 2015.</p>	

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	<p>initiated, staff was unable to locate resident. Police located resident at a restaurant down the highway from the facility around 8:00 p.m.</p> <p>Another evaluation by a licensed nurse, with services to be provided by the facility, was not done until 12/12/14. This assessment indicated Resident #A was confused, wanders day and night, agitated and knows person only, "states he wants to leave and go to Mississippi and Chicago, ...Judgment and memory is usually poor. Needs complete supervision. ... Attempts to leave facility in unsafe manner..."</p> <p>On 12/18/14 at 1:20 p.m., the Director of Nursing indicated a resident should be reevaluated if a significant change in behavior occurred.</p> <p>On 12/18/14, at 1:30 p.m., the Executive Director provided an undated policy, titled, "Elopement Assessment Policy and Procedures," and indicated it was the policy currently used by the facility. The policy indicated, "...Certain assisted living residents will be assessed for elopement risk on admission, readmission after hospitalization, presentation of exit seeking behavior including but not limited to...actual elopement, at the time of a scheduled</p>			

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R000217	<p>assessment if necessary, and/or as condition changes that would warrant an elopement assessment."</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review, observation, and interview, the facility failed to ensure</p>	R000217	1. The corrective action accomplished for Resident A was	01/30/2015

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	<p>service plans were updated, according to facility policy, to include interventions which addressed the risk of elopement, for 3 of 3 residents reviewed for being at risk of elopement. (Residents #A, #B, and #C)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #A was reviewed on 12/18/14 at 10:50 a.m. Diagnoses included, but were not limited to, Alzheimer's disease.</p> <p>An Assessment and Service Plan for Resident #A, dated 7/14/14, indicated his, "Judgement and memory are generally good." The service/intervention was, "Needs monitoring and guidance and occasional redirection." The spaces next to "wandering" and "exit seeking" were not checked.</p> <p>A nurse's note on 9/28/14 at 12:00 a.m., indicated Resident #A had left the facility without staff knowledge and was found by the police at a restaurant down the highway. The police indicated to the facility he was, "confused and disoriented."</p> <p>A nurse's note on 10/28/14 at 4:45 a.m. indicated, "Res[ident] tried to exit</p>		<p>discharged to another senior living community with a memory care unit on 12/19/14. Resident B was assessed and moved to the Memory Care unit at Country Charm Village. Resident C's assessment was completed and interventions put in place. All doors are locked and resident is currently on hourly checks. Physician and resident's POA have been contacted.2. The facility will work with resident's and attending physician to transfer to Memory if resident is determined can no longer safely remain in Assisted Living.3. On December 18, 2014, immediately following the surveyors's exit; the Executive Director implemented a New Resident Wandering Binder. The Resident Wandering Binder has all current resident's information, picture, and a checklist of what procedure staff shll follow should a resident wander from the facility. This binder will be kept at the Nurses Clinic on the AL unit and contains Memory Care unit resident information.The DON shall create a current resident list and review to ensure, a complete and current service plan reflecting at risk for elopement with appropriate interventions.The DON shall be responsible to review and audit all residents with the potential for exit seeking and wandering behaviors weekly for four weeks, then oncwe per month for three months, then quarterly to ensure</p>				

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	<p>through the front entrance x 2 this shift, res[ident] then began to wander around the facility to each door trying to exit..."</p> <p>A nurse's note dated 10/30/14 at at 7:40 p.m., indicated, "Res[ident] exit seeking. Put on 15 min[ute] checks."</p> <p>A nurses's note dated 11/30/14 at 7:00 p.m., indicated resident had not come down for dinner, and when a search was initiated, staff was unable to locate resident. Police located resident at a restaurant down the highway from the facility around 8:00 p.m.</p> <p>Resident #A's service plan was not updated until 12/11/14 with interventions and services to be provided for exit seeking and/or elopement behavior. One intervention was, "...will be cued and redirected as needed...Interventions are most of the time ineffective..."</p> <p>During observations on 12/18/14, at 9:00 a.m., 10:45 a.m., 11:03 a.m., and 1:15 p.m., Resident #A was sitting in lobby near front door, or wandering around lobby/front door area.</p> <p>2. The clinical record of Resident #B was reviewed on 12/18/14 at 1:20 p.m. Diagnoses included, but were not limited to, dementia with "behavior</p>		<p>resident service plans reflect elopement potential and specific resident inventions.4. The Executive Director shall review the service plan audits and monitor the Resident Wandering Book after new admissions for 30 days, then monthly thereafter.5. The date the systemic changes will be completed by January 30, 2015.</p>	

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	<p>(wandering)."</p> <p>Resident #B was admitted to the facility on 11/16/14. His Level of Service Assessment, dated 11/17/14, indicated he was always disoriented, his decision-making was severely impaired, and he, "Wanders within the facility...May wander outside, health and safety may be jeopardized..." No interventions were found in the resident's record which addressed his wandering behavior documented at the time of his admission through 12/8/14.</p> <p>A nurse's note, dated 11/19/14 at 10:00 a.m. ("late entry for 11/18/14") indicated Resident #B was, "very confused at times. Multiple exit seeking behaviors noted this evening. Res[ident] asking people to let him out front door. Res[ident] attempted to walk behind visitors to exit."</p> <p>On 12/2/14, Resident #B was moved to the Memory Care Unit.</p> <p>An "Preliminary Assessment" was not done on Resident #B until 12/8/14, which included the resident's service plan. The assessment indicated the resident wanders day and night, was confused, had significant memory loss, was disoriented to person, place and time,</p>			

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	<p>"Attempts to leave facility in unsafe manner," ...Resident has been identified as an elopement risk." The only interventions found in the resident's record which addressed his safety due to being an elopement risk, were, "[name of resident] will be checked for safety and comfort...staff will talk with resident to evaluate any needs...monitor to prevent inappropriate exit seeking...near doors and when out of building on supervised activities."</p> <p>3. The clinical record of Resident #C was reviewed on 12/18/14 at 10:20 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and depression with anxiety.</p> <p>An Assessment and Service Plan, dated 7/29/14, indicated Resident #C's "Judgement and memory are generally good. Needs monitoring and guidance and occasional redirection." Her behaviors included, "wandering."</p> <p>A physician's progress note, dated 9/30/14, indicated, "Staff notes [increased] behaviors x several days. Tried to leave building, staff [and] pt. (patient) friend had some difficulty persuading pt. to move away from exit doors. Staff notes [increased] confusion..."</p>			

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	<p>No updates to Resident #C's service plan, with interventions and/or services to be provided which addressed the risk of elopement, were added to the service plan until 11/18/14.</p> <p>An assessment and service plan, dated 11/18/14, indicated, "wanders aimlessly...confused...wanders within facility. Easily redirected...disoriented daily...Wanders aimlessly or non-goal directed within the facility without leaving the building." Interventions included, "checked for safety and comfort...talk with resident to evaluate any needs...monitored near doors and when out of building on supervised activities..."</p> <p>On 12/18/14, at 1:30 p.m., the Executive Director provided an undated policy, titled, "Elopement Assessment Policy and Procedures," and indicated it was the policy currently used by the facility. The policy indicated, "If it is determined that the resident may be a risk for elopement, immediate interventions should be put into place..."</p> <p>This same policy indicated if a resident was determined to be a risk for elopement, a "Wandering Resident Information Sheet" should be completed.</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 12/18/2014
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NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227
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	<p>This should include a photo. The sheet should be placed in the "Resident Wandering Binder in the designated area for quick staff access."</p> <p>In an interview with the Executive Director on 12/18/14 at 3:30 p.m., she indicated she did not know if the facility had a Resident Wandering Binder. In an interview with the Director of Nursing on 12/18/14 at 3:35 p.m., he indicated he did not know about a Resident Wandering Binder. At 3:45 p.m., 2 nurses in the Clinic indicated they thought there was a binder but they weren't sure where it was. At 3:50 p.m., the binder, which had been in the Memory Care unit, was provided. Residents #A, #B, and #C's information and pictures were not in the binder. The Executive Director indicated, at that time, the binder was not current.</p>			