STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NORTHVIEW CARE CENTER	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaint IN00123277. Complaint IN00123277 substantiated, state deficiencies related to the allegation are cited at F 9999. Survey date: January 26, 2013 Facility number: 000562 Provider number:155718 Aim number: 100267150 Surveyor: Jeri Curtis, RN Census bed type: Residential: 22 Total: 22 Census payor type: Other: 22 Total: 22 Sample: 3 These state findings are in accordance with 410 IAC. Quality Review completed by Debora Barth, RN.	R0000	Submission of the plan of correction and credible allegation does not constitute an admission by the certified provider at Community Northview Care Center. The Community Northview Care Center also does not constitute admission that the allegations contained in the survey report are true and accurate portrayal of the provision of nursing care and services at this health facility. Community Northview Care Center as licensed and certified provider recognizes it obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. The following will serve as the plan of correction and allegation of compliance for the cited deficiencies. If you have any questions, please contact me. Thank you!	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R0052	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. 1. 5-1.2(a) Resident Rights Residents have the right to be free from: (5) neglect These State Residential Rules were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure supervision to prevent the elopement of 1 (Resident A) resident in the sample of 3 reviewed for elopement. Findings include: During the 1/26/13, 1:00 P. M., entrance tour with Licensed Practical Nurse (LPN #1), Resident A was observed in the room of another resident, on the hands and knees, looking under the bed. Resident A, was dressed in jeans, layered t-shirts, and socks. Resident A was re-directed to an activity by LPN #1.	R0052	The correction action accomplished for those residents affected by the deficient practice are: Resident A's care plan has been reviewed and updated as indicated for exiting. All exit doors have been checking for proper closing upon exiting or entering the building. The kitchen door closure was replaced the same day of the event on January 24, 2013. Other residents having the potential for exit seeking practice will be identified and the corrective action taken: All residents have the potential to be exiting seeking due to their dementia diagnosis and Alzheimer's type symptoms. Care plans will be reviewed and updated as needed. All exit doors have been assessed for proper closing upon entering and exiting the building. Staff were in-serviced on January 24, 2013 to check the door after opening to assure the doors are secured. The systemic changes made to ensure that this deficient practice does not recur are: All exit doors are checked each shift for proper closing. Signs have been posted on the inside and	02/06/2013

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	During a 1/26/13, 2:35 P.M., interview, the Activity Director (#1) indicated the facility was totally secured. Activity Director #1 indicated all doors had key pad codes for entry and exit and there were no alarms. Activity Director #1 indicated at 1:00 P.M., 1/24/13, a police officer rang the front door bell and said he had one of our residents in the squad car. Activity Director #1 indicated the staff were unaware Resident A had gotten out of the facility. Activity Director #1 indicated Resident A was wearing pants, 2 long sleeved shirts, socks, and moccasins. Activity Director #1 indicated Resident A was not wearing a coat. Activity Director #1 indicated Resident A had a behavior of exit seeking. Activity Director #1 indicated Resident A would go to a door, push the buttons on the code box, and stand there until re-directed. LPN #1 was interviewed at 3:00 P.M., 1/26/13, and indicated the police and a lady (unknown) who lived in the neighborhood had returned Resident A the afternoon of 1/24/13. LPN #1 indicated the police officer rang the entrance bell and said he had someone from the facility who		outside of all exit doors to check the door has shut properly after opening it and leaving the area. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: The Director of Nursing will check the shift door checks log Monday through Friday for 4 weeks, 3 x's a week for 4 weeks, and 2's a week for 4 weeks. 12 weeks Any concerns will be reported to the Administrator and discussed at the monthly Quality Assurance Committee and appropriate action plans will be written and implemented.	

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	appeared to be lost. LPN #1 indicated a housekeeper had responded the resident could not belong to the facility because they were totally secured. LPN #1 indicated they looked outside into the police car and saw it was Resident A. LPN #1 indicated she was told that, while wandering the neighborhood, Resident A had knocked on the door of the lady who had accompanied the police officer on the return of Resident A. LPN #1 indicated the lady had taken the resident into her home and had called the police. LPN #1 indicated she was unsure how long Resident A had been outside of the facility. LPN #1 indicated Resident (A) had been seen by staff during the 1/24/13, lunch, which started at 11:45 A.M., and was returned to the facility by the police at 12:50 P. M. LPN #1 indicated, after Resident A was returned to the facility, a complete body assessment was done. LPN #1 indicated she had removed the clothing of Resident A and had evaluated the feet, hands, and ears, for frost bite. LPN #1 indicated there were no injuries with the exception of a small red area on the ring finger of the right hand.			

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	LPN #1 indicated Resident A was ambulatory, could follow some commands, and had a habit of wandering into other rooms in the immediate vicinity of her own. LPN #1 indicated Resident A was easily re-directed. LPN #1 indicated the staff had immediately done a head count of all residents and had checked all exit doors for functioning following the 1/24/13, elopement and return of Resident A. LPN #1 indicated each resident room had double hung patio doors, 1 side window, 1 side slider, which were secured with a keyed lock, and a dead bolt. LPN #1 indicated she had checked all exits on 1/24/13, and the Maintenance Director had come in and had checked the magnet lock door system. Social Services(SS #1) was interviewed at 4:10 P.M., 1/26/13, and indicated she understood the cameras had shown Resident A had probably exited through the kitchen on 1/24/13. SS #1 indicated she had checked and the outside temperature had been 24 degrees at the time of the 1/24/13, elopement. SS #1 indicated she believed an air			

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	power clamp on the kitchen door had failed to make connection and the door had not locked as it should with the last person entering and exiting. The Director of Nursing (DoN) was interviewed by telephone at 2:25 P. M., 1/26/13, and indicated on 1/24/13, she had been at a meeting within the hospital complex area down the street from the facility. The DoN indicated she had returned to the facility at 12:25 P.M., went to her office, and from the back patio door saw a police car pull into the lot. The DoN indicated she had gone out to speak with the police officer who had returned Resident A. The DoN indicated the facility had not been aware Resident A was not in the facility. The DoN indicated after assuring all residents were accounted for, she had interviewed staff. The DoN indicated staff had last seen Resident A at 12:00 P. M., 1/24/13, at lunch. The DoN indicated no one had seen Resident A exiting the front door. The DoN indicated she had viewed all 4 camera sites from the 1/24/13, 12:00 P. M. time frame. The DoN indicated Resident A was viewed entering the kitchen three times, and exiting twice. The DoN indicated the			

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	kitchen camera did not include a view of the back exit door. The DoN indicated she and the Maintenance Director concluded Resident A had exited the rear kitchen door. The DoN indicated when interviewed, staff had said the back kitchen exit door did not always work as it should. The DoN indicated this had never been reported to herself nor maintenance prior to the elopement. The DoN indicated the Maintenance Director had purchased and attached a new air power closure for the back kitchen door on 1/24/13. The DoN indicated when the 1/24/13, camera sites were viewed, it last showed a visual of Resident A in the kitchen area at 12:19 P.M. The DoN indicated Resident A would have been gone from 12:20 P.M. to the 12:50 P.M. return by the police, 30 minutes later. The DoN indicated she had not been given the name of the neighbor whose house Resident A had approached, and did not know how long she might have been inside and warming at the neighbor's house. The Don indicated all residents were placed in the facility because they were at risk for wandering so the facility was totally secured.			

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	This State Residential Rule relates to Complaint IN00123277.			

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R0148	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: (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. 2. 5-1.5(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: (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	R0148	The correction action accomplished for those residents affected by the deficient practice are: Resident A's care plan has been reviewed and updated as indicated for exiting. All exit doors have been checking for proper closing upon exiting or entering the building. The kitchen door closure was replaced the same day of the event on January 24, 2013. Other residents having the potential for exit seeking practice will be identified and the corrective action taken: All residents have the potential to be exiting seeking due to their dementia diagnosis and Alzheimer's type symptoms. Care plans will be reviewed and	02/10/2013

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	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. Based on observation and interview, the facility failed to ensure the proper functioning for closure of 1 of 5 magnetized exit doors within the facility to prevent the elopement of 1 (Resident A) resident in the sample of 3 reviewed for elopement. This had the potential to affect 22 residents out of a total population of 22 in the secured Alzheimer's facility. Findings include: During a 1/26/13, interview, Licensed Practical nurse (LPN #1) indicated, following the 1/24/13 elopement of a resident, the Director of Nursing (DoN) had posted a security check of all exits which was to be completed at least twice on each shift. LPN #1 indicated all staff were to read and sign the security check inservice prior to reporting to duty. The Day Cook #1 was interviewed at 3:45 P.M., 1/26/13, and indicated the air pressure device on the back kitchen exit had malfunctioned on 1/24/13. Day Cook #1 indicated it		updated as needed. All exit doors have been assessed for proper closing upon entering and exiting the building. Staff were in-serviced on January 24, 2013 to check the door after opening to assure the doors are secured. The systemic changes made to ensure that this deficient practice does not recur are: All exit doors are checked each shift for proper closing. Signs have been posted on the inside and outside of all exit doors to check the door has shut properly after opening it and leaving the area. The corrective actions will be monitored to ensure the deficient practices do not recur per the following: The Director of Nursing will check the shift door checks log Monday through Friday for 4 weeks, 3 x's a week for 4 weeks, and 2's a week for 4 weeks. 12 weeks. The maintenance director will ongoingly check the door closures 3 x's a week and immediately report any concerns to the Administrator/designee. Any concerns will be reported to the Administrator and discussed at the monthly Quality Assurance Committee and appropriate action plans will be written and implemented.	

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	had been determined that this was the door which Resident A had exited on 1/24/13. The Maintenance Director #1 was interviewed by telephone at 6:00 P. M., 1/26/13, and indicated each secured exit had a magnetic lock system with a back-up which could release manually with the door handle. Maintenance Director #1 indicated the system was not alarmed. Maintenance Director #1 indicated a contracted company came in periodically to check the magnetized system. The Maintenance Director indicated he was at the facility only part time and checked the door closures whenever he was there. Maintenance Director #1 indicated, following the 1/24/13 elopement, he had established a security check of all exits which was to be completed at least twice on each shift.. This State Residential Rule relates to Complaint IN00123277.			