STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDERS GLEN	334 S CHERRY ST, WESTFIELD, , 46074

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00379111 and IN00379114. Complaint IN00379111 - Substantiated. State deficiencies related to the allegations are cited at R0052. Complaint IN00379114 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: May 16 and 17, 2022 Facility number: 005657 Residential Census: 98 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 24, 2022.	R 0000	This plan of correction constitutes Sanders Glen's written allegation of compliance for the deficiency cited in the survey completed May 17, 2022. Submission of this Plan of Correction does not constitute an admission that a deficiency exists or was cited correctly. This Plan of Correction is being submitted to meet state and federal requirements. Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements.	
R 0052	Residents' Rights - Offense	R 0052	**R052 Residents' Rights**	06/02/2022

	410 IAC 16.2-5-1.2(v)(1-6) (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, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia, with wandering and exit seeking behaviors, was free from neglect when she exited the facility and was found lying on the ground outside the facility front entrance door without facility staff knowledge for 1 of 3 residents reviewed for risk of elopement. (Resident B) Resident B sustained a fractured pelvis. Finding includes: On 05/16/2022 at 9:22 a.m., the door to enter the facility was locked. The code to unlock the door was observed posted, with instructions for use, immediately to the right of the exterior of the door. Once inside the facility, on the wall immediately to the right of the entrance door, was a sign with the code to silence the		This facility maintains policies and procedures to ensure all residents are provided a safe and healthy environment, free of harmful conditions. *Corrective action for affected identified resident* Affected resident, based on specific change of condition, has been discharged to a facility with a higher level of acuity. *Identification and corrective action for other residents with the potential to be affected:* A review of all resident records identified one additional resident with the potential to be affected. A review of the additionally identified resident's assessments, progress notes and interviews, determined resident is not a wander risk at this time. A feature on facility's nurse call pendants has been enable for this resident, to alert staff if he/she	

	alarm and allow exit to the outside without triggering the alarm. Residents were observed to mingle and visit in a lobby area. The record for Resident B was reviewed on 05/16/2022 at 10:21 a.m. Diagnosis included, but was not limited to, dementia without behavioral disturbance, diabetes mellitus, vitamin D deficiency, aortic valve stenosis, acute pain and gastro esophageal reflux disease. A physician's order indicated the resident was ordered to receive Aricept 5 mg (milligrams) daily (a medication used to treat dementia) and the medication was increased to 10 mg daily on 03/11/2022. The resident's current "Service Plan For Residential Care," dated 03/28/2022, indicated a "parameter" of "behavior" with services provided "Monitor for early warning signs of problematic behavior." A "Level of Service/Evaluation Assisted Living" assessment, dated 03/28/2022, indicated Resident B was "Oriented to person, place and time OR sufficiently oriented to function independently if in familiar surroundings," judgment was described as "Decisions are made in an organized manner, daily routine and decisions are		leaves the external perimeter of coverage. Doors and door alarms were all determined to be in working order. *Measures to prevent recurrence:* Education reviewed with all care staff to identify early signs of change in conditions for residents. Education provided to all staff, specific to alerting Administrator, Director of Nursing and/or Designee in the event a cognitively impaired resident attempts to or exits the building alone, or any resident who attempts to or exits the building at an inappropriate time of day or displaying poor judgement. A Nurse call pendant feature, which activates when a resident breaches the external perimeter of coverage, has been installed to assist with unplanned absences from the building. Prospective residents who assess at risk for wandering, will not be admitted to this facility. Current residents who asses at risk for wandering, but not exit	

	consistent, reasonable, and organized reflecting lifestyle, culture and values," and memory was assessed to be "Has difficulty remembering and using information. Requires at least daily cueing from others. Cannot read written directions." Resident B's behavior was described as "Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions. OR Attitudes, habits and emotional states limit the individual's type of living arrangement and companions" and Wandering [Defined as: moving with no rational purpose, seemingly oblivious to needs or safety] was assessed to be "Does not wander. May be chair or bed bound." A progress note, dated 04/13/2022 at 8:56 a.m., indicated Resident B was "noted wandering halls during night shift and trying to open doors to get out on phase 2." The note indicated the resident was "found in the phase 2 dining room" the same morning at breakfast time stating she was "lost".		seeking, per the bi-annual assessment or upon a change in condition, will be provided a pendant, which activates when breaching the external perimeter. Current residents who assess at risk for exit-seeking behaviors, will be discharged to a more appropriate level of care. *<u>How will the facility monitor and who is responsible:</u>* Administrator, Director of Nursing and/or Designee will monitor progress notes utilizing a 24 Hour Report feature through Point Click Care, a minimum of 5 days per week to identify potential changes of condition. Reported change of condition or concerns will be evaluated through the Inter Disciplinary Team to determine appropriateness for continued stay, need for re-assessment or intervention action.	

On 04/24/2022 at 5:31 a.m., the progress notes indicated the resident was "wandering during nightshift" and was "trying to leave out the front entrance" stating she was "lost" and trying to figure out "how to get home".

The progress notes indicated the residents' physician was notified of the resident's increasing behavior at night and distress that she felt "lost".

Documentation was lacking to indicate a reply to the physician's notification had been received.

On 04/27/2022 at 11:52 a.m., progress notes indicated the resident was "wandering around" but was easily directed.

On 04/29/2022 at 4:01 a.m., the progress notes indicated "Dietary Director arrived at the building and found resident on the ground at the entrance...the resident complained of hip pain" and 911 was called and the resident was transported to the emergency room.

During an interview, on 05/16/2022 at 11:26 a.m., the Director of Nursing (DON) indicated Resident B was known to wander throughout the facility and would often sit in the lobby area and visit with other residents. When in the lobby, Resident B had been observed to frequently silence the

entrance door alarm by putting in the code on the code pad, but to her knowledge, the resident had never been known to attempt to exit this door or any other door in the facility. The DON indicated on the night of 04/29/2022, staff had checked the door "30 minutes" prior to the dietary manager finding the resident outside, but did not see anything unusual.

On 05/16/2022 at 1:45 p.m., a telephone interview was conducted with QMA 1, who verified she was working the night Resident B eloped from the facility. The QMA indicated CNA 2 had told her she found Resident B wandering in the halls at "about 2:30 a.m." the night of the elopement and assisted the resident back to her room. She stated the CNA had heard the resident "lock the door" prior to the CNA leaving the area. QMA 1 indicated she had gone to the entrance door "between 3:30 - 4:00" a.m., looking for the morning paper delivery. She indicated this was a normal occurrence at that time of night and she would get the morning papers for residents. She did not see the resident or anything unusual at that time and was surprised when the dietary director notified her he had found Resident B on the ground outside the facility because she had not heard the door alarm. The QMA indicated

the resident had increased behaviors of wandering throughout the facility since the increase in her Aricept in March 2022. She remembered "about a month ago", while she was in the Phase 2 dining room getting ice, she observed Resident B push the exit door to the patio outside, which caused the alarm to sound. The QMA indicated the alarm startled the resident and she jumped back from the door. At that time, QMA 1 escorted the resident back to her room and to bed, adding the resident, "didn't leave the building". The QMA could not remember the exact date of the event but stated she had documented the incident on a paper form. Multiple attempts to interview CNA 2 were unsuccessful.

During a telephone interview, on 05/16/2022 at 2:42 p.m., the Dietary Director (DD) indicated he arrived at the facility "sometime between 3:45 - 4:00 a.m." on 04/29/2022. He heard the resident yelling "help me, help me" and that her "hip hurt." He found the resident lying on the ground at the entrance to the facility. He didn't know what to do but knew he shouldn't move the resident, so he called 911 for assistance. When questioned, the DD could not recall what the resident was wearing at the time he found her. The DD indicated after the

ambulance arrived and was attending to Resident B, he notified nursing staff of the event. He knew the resident because she would often come to the dining room early in the morning, "around 5:00 a.m." and he would give her donuts. The DD indicated this was not an everyday occurrence, but often.

Resident B's emergency room and hospital records related to the event on 04/29/2022 were obtained on 05/17/2022 at 9:21 a.m. Review of the records indicated the following:

Emergency physician notes indicated Resident B had a "history of dementia...she states her stuffed cat escaped his room so she went looking for it...thinks she slipped on the ground and fell."

Hospital Nurse Practitioner (NP) notes indicated Resident B "...has a history of dementia...does have a stuffed cat which is very life-like in appearance...has problems differentiating the stuffed cat from a real cat. The patient tells me that her cat went missing from their room last night and she went outside to look for it...found...outside...by 1 of the healthcare workers. Patient apparently had a mechanical fall and landed on her left hip...X-rays of the left hip demonstrated an acute

comminuted fracture of the medial left pubis (fracture of the pelvis)...She does have both long -term and short-term memory issues...."

The resident was admitted to the hospital for surgical consultation, pain management and physical therapy.

A current facility policy, titled "Resident Assessment," dated as last updated on 04/05/2011 and received on 05/17/2022 at 11:33 a.m., indicated "Policy: Assessment will be performed by the Director of Nursing and/or licensed nurse designee. Data obtained during assessment is used to determine that residents' needs for care, treatment and/or develop a plan of care. Assessment is also used to determine resident's needs can be met by this Residential Care facility. Resident assessments will be completed semi-annually thereafter or upon an identified significant change...Procedure...The assessment is updated and revised, as frequently as the resident's condition warrants due to a major decline or improvement in the resident's health status and/or every six months..."

This State Tag relates to Complaint IN00379111.

	Based on observation, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia, with wandering and exit seeking behaviors, was free from neglect when she exited the facility and was found lying on the ground outside the facility front entrance door without facility staff knowledge for 1 of 3 residents reviewed for risk of elopement. (Resident B) Resident B sustained a fractured pelvis. Finding includes: On 05/16/2022 at 9:22 a.m., the door to enter the facility was locked. The code to unlock the door was observed posted, with instructions for use, immediately to the right of the exterior of the door. Once inside the facility, on the wall immediately to the right of the entrance door, was a sign with the code to silence the alarm and allow exit to the outside without triggering the alarm. Residents were observed to mingle and visit in a lobby area.			

The record for Resident B was reviewed on 05/16/2022 at 10:21 a.m. Diagnosis included, but was not limited to, dementia without behavioral disturbance, diabetes mellitus, vitamin D deficiency, aortic valve stenosis, acute pain and gastro esophageal reflux disease.

A physician's order indicated the resident was ordered to receive Aricept 5 mg (milligrams) daily (a medication used to treat dementia) and the medication was increased to 10 mg daily on 03/11/2022.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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