STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARMEL	301 EXECUTIVE DR, CARMEL, , 46032

(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 a State Residential Licensure Survey. Survey dates: June 13 and 14, 2023 Facility number: 010416 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 22, 2023.	R 0000		
R 0052	Residents' Rights - Offense 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;	R 0052	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1 resident affected by alleged deficient practice. Resident was found outside of community and brought back into community per staff. ED, MD and POA notified. 1 on 1 sitter initiated. Resident	07/20/2023

	(5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident with a diagnoses of Alzheimer's disease and dementia with behavioral disturbance was free of neglect when the resident used a metal wash arm (the part which shoots water) from the bottom of the dishwasher located in a common Bistro area, to chip away at a window frame, allowing him to disarm the safety locking mechanism, and climb out of the first floor window without staff knowledge for 1 of 7 residents reviewed for neglect. (Resident 500) Finding includes: During the entrance conference, beginning on 06/13/23 at 9:04 a.m., the Health and Wellness Director (HWD) indicated Resident 500 used a piece of the dishwasher to chip at the wood on the window frame in a common area. The piece from the dishwasher which was used was the bar that runs along the bottom and shoots water to clean dishes. It was found to be easily unscrewed from the dishwasher for descaling of the piece. An observation of the window in the Bistro area was made on		admitted to geri psych hospital on Sunday, June 4th. . How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All ambulatory residents with memory impairment have the potential to be affected by alleged deficient practice. Community identified 23 residents in community with memory impairment who also ambulate independently. . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All associates in-serviced on elopement, abuse, and resident rights. All ambulatory residents will be assessed for elopement risk. Residents who are at risk for elopement will see geri psych physician regularly until no longer warranted. Personalized interventions per resident will be initiated as needed.	

	06/14/23 at 3:40 p.m. On the left-hand upper side of the window, chipped out wood was noted, showing raw unfinished/unpainted wood. Outside the window was a round area with chimes and lights. It had a paved walking area, was not fenced in and opened to the parking lot. The record for Resident 500 was reviewed on 06/14/23. Diagnoses included, but were not limited to, Alzheimer's disease and unspecified dementia with behavioral disturbance. The resident admitted to the facility on 05/22/23. The service plan, dated 05/25/23, indicated Resident 500 was not always oriented to place and he demonstrated anxious, disruptive, or obsessive behaviors which required additional attention. It also indicated the resident attempted to exit the building without needed supervision. There was no elopement risk assessment found in the record. There was no additional monitoring or checks found in the record. A nursing note, dated 05/24/23 at 2:25 a.m., indicated the resident was confused as to where he was and why he was		. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ED to review elopement assessments prior to move in and 1x monthly during collaborative care meetings for 6 months to ensure appropriate interventions in place.	

there. He was asking about his wife.

A nursing note, dated 05/24/23 at 11:08 a.m., indicated the physician was notified of the resident's exit seeking behavior.

A nursing note, dated 05/26/23 at 4:06 a.m., indicated the resident had been up most of the night and was wondering the halls of the facility. He also displayed confused thoughts.

A nursing note, dated 05/31/23 at 10:48 p.m., indicated the resident was exit seeking and going into other resident's rooms. He was not easy to redirect on the shift. The service plan indicated, "...Direct to an appropriate wandering space...resident looking for his car, looking for his wife. Redirect with food, ice cream, something to do. Likes to be given task. Packs items in his room. Doesn't like to be told no, redirect him...."

A nursing note, dated 06/01/23 at 12:53 p.m., indicated the resident had increased agitation that morning. He also had an angry affect at times that day.

A nursing note, dated 06/02/23 at 11:01 p.m., indicated the resident broke out the window with a metal item obtained from the dishwasher in the Bistro area to take off the exterior window. The resident walked

down the driveway and was intercepted by the receptionist who took the resident into her car and drove him back to the front entrance of the facility. The resident did attempt to "make a run for it". Staff was able to surround the resident to keep him from leaving the facility premise. The resident was "extremely agitated" and broke a large stick off a tree and was swinging it around, the resident also had the metal item from the dishwasher in his other hand.

During an interview, on 06/14/23 at 1:50 p.m., RN 1 indicated Resident 500 never made an attempt to leave on her shift. He was angry at the world and thought someone had stolen his money. The family had also misled him to believe he was only at the facility for rehabilitation. She would give him his medications and he would take the cup, put it in his pocket and she would have to "chase" him to get the medications back. She would have to call his wife to come to the facility so he would take his medications.

During an interview, on 06/14/23 at 2:18 p.m., CNA 2 indicated on the day of the elopement she was in her neighborhood (work area) that evening. She took a break and observed Resident 500 outside.

During an interview, on 06/14/23 at 2:24 p.m., LPN 3 indicated she had administered medications to Resident 500 around 8:20 p.m. He was very alert and anxious. He was acting normal. He did not like to sit; he wandered in and out of rooms. He was very high functioning, made eye contact, and would seek attention. He was not happy. He "swore" he lost his dogs in the parking lot. Every day he talked about his dogs. He had two. He truly believed his dogs were here (at the facility) when he came to the facility, and they were out in the lawn area somewhere. She went on break, that night, around 8:24 p.m. When she returned, around 8:55 p.m., she had heard someone was out. She, as well as other staff members, responded to the front door. The receptionist was in her car in the parking lot and had Resident 500 in her car. She drove him to the front entrance. When the resident saw her and her white coat, he got out of the car and tried to make a run for it.

During an interview, on 06/14/23 at 2:51 p.m., the HWD indicated after Resident 500 had been admitted his spouse informed the facility he was allowed to go out into the neighborhood at home. He was not exit seeking, he was looking for his wife and his money. She was not

informed he was looking for his dogs outside. She did not feel an elopement assessment was needed for Resident 500.

During an interview, on 06/14/23 at 4:04 p.m., Receptionist 4 indicated she was getting ready to leave and was in her car, in the parking lot. She got to the stop sign (at end of property) and pulled off. She saw Resident 500 going across the street. He had stepped into the street. She tried to start a conversation, asked him where he was going and told him she would take him. He got into her car, and she returned him to the facility. The nurse assisted him out of the car, and he did try to run at first when he realized he was going back into the facility. She further indicated, when he was attempting to cross the street, he had the metal pole from the dishwasher in his pocket. When staff was trying to get him back into facility, he picked up a stick and swung it.

A facility document, titled INCIDENT INVESTIGATION-"Allegations Involving Brookdale Resident(s)," dated 06/02/23 and was received from the HWD on 06/14/23 at 9:36 a.m., indicated "...On 6.2.23 around 9:00 pm resident (500) eloped from community and was found by staff in front of community at 9:03 pm...Resident states he

	was leaving community to go home and he wanted his money..." Interview Summary: Receptionist 4 "states she was sitting in the parking lot after her shift talking on the phone when she saw resident...outside in front of the community...." Receptionist 4 "...states she drove her car over and asked him if he wanted a ride. He got in the car, and she called staff at community and had them come out and help her get resident back in community...." LPN 3 indicated "...she last saw resident...in common area outside his apartment at 8:20 pm...." Timeline: Receptionist 4 clocks out from shift and goes to car at 8:47 p.m. She sees Resident 500 outside the community at 9:03 p.m. HWD arrives at community and completes investigation at 9:10 p.m. Summary of Findings: "...Upon investigation it was found that around 9:00 pm resident removed spray arm from dishwasher in the bistro common area and used it to pry out wood window stop in bistro window. He then exited the community through the window and closed the window behind him...." A current policy, titled "Abuse, Neglect & Exploitation Policy," dated as last revised 05/2021 and received from the Executive Director on 6/14/23 at 4:30 p.m., indicated "..."Neglect" is defined				

in Indiana as an act or omission which places a resident in a situation that may endanger the resident's life or health...."

A current policy, titled "Evaluation Process Policy," dated as last revisited on 1/2019 and received from the Executive Director on 06/14/23 at 4:30 p.m., indicated "...Residents should be evaluated to determine the level of care and services needed...."

A current policy, titled "How To: New Resident Dementia Care-77," dated as last revised November 2020 and received from the Executive Director on 06/14/23 at 4:30 p.m., indicated "...Upon admission/move in to an Alzheimer's and Dementia Care area, it can be reasonably anticipated that a resident may demonstrate confusion, fear, anxiety, depression, anger and may pose a risk of elopement from the community...Prior to admission the Executive Director (ED) and Health and Wellness Director (HWD) will review the care needs of residents who have anticipated confusion, fear, anxiety, depression, anger and may pose a risk of elopement from the community...Specific actions steps for individual residents will be established in the Service Plan...."

Based on observation, interview

and record review, the facility failed to ensure a resident with a diagnoses of Alzheimer's disease and dementia with behavioral disturbance was free of neglect when the resident used a metal wash arm (the part which shoots water) from the bottom of the dishwasher located in a common Bistro area, to chip away at a window frame, allowing him to disarm the safety locking mechanism, and climb out of the first floor window without staff knowledge for 1 of 7 residents reviewed for neglect. (Resident 500)

Finding includes:

During the entrance conference, beginning on 06/13/23 at 9:04 a.m., the Health and Wellness Director (HWD) indicated Resident 500 used a piece of the dishwasher to chip at the wood on the window frame in a common area. The piece from the dishwasher which was used was the bar that runs along the bottom and shoots water to clean dishes. It was found to be easily unscrewed from the dishwasher for descaling of the piece.

An observation of the window in the Bistro area was made on 06/14/23 at 3:40 p.m. On the left-hand upper side of the window, chipped out wood was noted, showing raw unfinished/unpainted wood.

Outside the window was a round area with chimes and lights. It had a paved walking area, was not fenced in and opened to the parking lot.

The record for Resident 500 was reviewed on 06/14/23. Diagnoses included, but were not limited to, Alzheimer's disease and unspecified dementia with behavioral disturbance.

The resident admitted to the facility on 05/22/23.

The service plan, dated 05/25/23, indicated Resident 500 was not always oriented to place and he demonstrated anxious, disruptive, or obsessive behaviors which required additional attention. It also indicated the resident attempted to exit the building without needed supervision.

There was no elopement risk assessment found in the record.

There was no additional monitoring or checks found in the record.

A nursing note, dated 05/24/23 at 2:25 a.m., indicated the resident was confused as to where he was and why he was there. He was asking about his wife.

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front entrance of the facility. The resident did attempt to "make a run for it". Staff was able to surround the resident to keep him from leaving the facility premise. The resident was "extremely agitated" and broke a large stick off a tree and was swinging it around, the resident also had the metal item from the dishwasher in his other hand.

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	confusion, fear, anxiety, depression, anger and may pose a risk of elopement from the community...Specific actions steps for individual residents will be established in the Service Plan...."			

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