STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER PLACE	741 PARK EAST BLVD, LAFAYETTE, , 47905

(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 Complaints IN00359939, IN00360638, IN00360972 and IN00361377. This visit included a Quality Assurance Walk Through Survey. Complaint IN00359939 - Unsubstantiated due to lack of evidence. Complaint IN00360638 - Substantiated. State deficiency related to the allegations is cited at R0052. Complaint IN00360972 - Substantiated. State deficiency related to the allegations is cited at R407. Complaint IN00361377 - Unsubstantiated due to lack of evidence. Survey dates: August 25, 26, 27 and 30, 2021 Facility number: 013045	R 0000		

	Residential Census: 85 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 7, 2021.			
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; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure residents were free from neglect, related to a resident who had an elopement six days previously, to his patio door alarm sounding for at least 9 minutes prior to a staff member checking the door, another resident with a dementia diagnosis was found in the facility courtyard unsupervised and the facility failed to thoroughly investigate 2 of 3 elopements being reviewed for neglect (Residents B and C).	R 0052	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident B was moved off memory care unit and into apartment with no exterior patio door on 8/30/21. Resident B continues on visual safety checks until alternate facility placement found. Resident C continues to reside on memory care unit. 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 residents have the potential to be affected. Residents with exterior patios had new elopement risk assessments completed on 9/2/2021. All patio door alarms were tested to ensure 24 hour alert on 8/30/21. Call system provider reviewed all alarms and	09/21/2021

	This deficient practice resulted in Resident B feeling anxious related to being placed on the same Memory Care unit as Resident C (who was his wife) and he was afraid of her due to previous incidents, which occurred prior to their admissions to the facility. Findings include: 1. A Confidential interview was conducted during the course of the survey. The Confidential interviewee indicated PCA 7 came into work on 8/30/21 to write her statement for Resident B's elopement off the facility grounds, which occurred on 8/25/21 and he was found down by the Circle K gas station. PCA 7 brought him back to the facility. The Confidential Interviewee indicated the nurses did not carry the pagers on their person to listen to the call lights or door alarms pages because it was "supposed to be" the aides responsibility to answer the page alerts. If the aides were busy, then they answered them as soon as they finished what they were doing. The Confidential Interviewee indicated she heard Resident B indicate he was scared of Resident C and he did not want to be alone with her. A typed statement, dated 8/25/21, by LPN 5 indicated she and LPN 10 were sitting at the		pagers; verified operations on site on 9/16/21. All Memory Care windows will be re-checked for working safety mechanisms again by 9/21/21. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Staff re-educated by 9/13/21 on Abuse Policy and Resident Rights, including but not limited to neglect and involuntary seclusion. Elopement drills including door alarm activation completed on 9/1/21. Staff re-educated by 9/13/21 on Elopement Policy and door alarms, including but not limited to immediate response to door alarms, investigation of the situation, and interviews/statements. New hire orientation to include door alarm response skills validation. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? CQI tools will be initiated by 9/18/21 as monitoring tools. The Door Alarms CQI tool will be completed by the Executive Director /designee 3 days a week x 2weeks, weekly x 4 weeks, then monthly until compliance is maintained for 6	

	nurses' station when PCA 7 told them Resident B was not in his apartment. She asked when he was last seen and LPN 10 indicated when she gave him his medication. All three of them went to search for him. She and LPN 10 met up outside in the front of the facility and this was when they observed Resident B walking down the street past (Name of a Health Care Center), then PCA 7 and CNA 10 both ran to get him and brought him back to the facility. During an interview, on 8/25/21 at 1:57 p.m., LPN 3 (the Floating Clinical Director acting as the Interim Director, LPN 4 (the Clinical Support Specialist) and LPN 6 (Newly hired DNS orienting) were in attendance. LPN 3 indicated Resident B left his apartment on 8/19/21, through his patio door without signing out LOA (leave of absence). He walked 0.2 miles going North, became confused as to where he was and went into (Name of Health Care Center). He was able to tell the staff at (Name of the Healthcare Center) the name of the facility he lived at, but was confused as how to get back home. They called the facility, then a staff member went and picked him up in the facility bus. During an interview, on 8/26/21 at 12:44 p.m., the Executive Director (ED), LPN 1 (the		consecutive months. If threshold of 100% is not met, the results will be reviewed by the IDT team and an action plan will be developed and/or disciplinary action. The Elopement CQI tool will be completed by the Executive Director/designee weekly x 4 weeks, then monthly until compliance is maintained for 6 consecutive months. The CQI tools will be overseen by the Director of Nursing and Executive Director/designee. Date the systemic changes will be completed; All systemic changes will be completed by 9/21/2021	

	Director of Clinical Services), LPN 3 and LPN 4 were in attendance. While reviewing information, which was provided by the ED regarding the elopement of Resident B on 8/19/21, a typed, unsigned interview, dated 8/25/21, with LPN 5's name typed at the bottom of the paragraph indicated Resident B had eloped again on 8/25/21. There was no date or time listed in the typed interview as to when this event occurred. The ED was asked if this interview was regarding the elopement on 8/19/21 or if Resident B had eloped a second time and she indicated the resident eloped again last night (8/25/21) at approximately 7:30 p.m., and he got down to the (Name of the Healthcare Center) he had walked to previously before the staff could reach him. During this time, LPN 4 printed the history of Resident B's patio door alarm alerts for 8/25/21. This document was reviewed at this time with the attendees of the interview and the following was indicated: At 9:07 a.m., Response received at 9:07 a.m. LPN 4 indicated the resident opened the door to get fresh air as he frequently did throughout the day. At 9:08 a.m., the alarm announced on the nursing			

	staff's pagers 10 times the door was open. "This alert was never responded to." LPN 4 indicated the staff responded to the alarm, but they could not close the door to reset it because the resident was sitting in his apartment with the door open to get fresh air. LPN 4 indicated the door alarm alerted 9 times, then it sent a message indicating the door alarm was never responded to by a staff member. At 1:37 p.m., Response received at 1:37 p.m. LPN 4 indicated the resident opened his door for fresh air and was educated not to open his back patio door due to the alarm sounding. At 1:51 p.m., Response received at 1:52 p.m. LPN 4 indicated the resident had the door open to get fresh air. At 4:59 p.m., Response received at 4:59 p.m. LPN 4 indicated the resident had the door open to get fresh air. At 7:25 p.m., Response received at 7:26 p.m. LPN 4 indicated the resident opened the patio door to get fresh air. At 7:30 p.m., Response received at 7:30 p.m. LPN 4 indicated the resident opened the patio door to get fresh air. At 7:33 p.m., the alarm was			

	announced on the nursing staff's pagers 2 times. Response received at 7:42 p.m. (9 minutes later). LPN 4 indicated PCA 7 responded to the door alarm at 7:42 p.m. When she arrived to his apartment he was not in there and the door was open. She notified the nurses and the staff began to look for him and he was found down by the (Name of Health Care Center) again. At that time, the Interim DNS indicated on 8/25/21 prior to the resident leaving the facility the staff noticed Resident B's cognition was "off," so the nurse notified his daughter to get permission to order a Urinalysis (UA) to be done Stat (due to when a test was ordered Stat, there was an additional fee charged to the family, so permission was needed to order the test stat). The daughter indicated she would come and take him to urgent care, but prior to getting him to urgent care for the UA test he eloped from the facility. At 8:24 p.m., Response received at 8:24 p.m. LPN 4 indicated a staff member was sitting with Resident B at this time. The patio door was opened by the resident's daughter. She sat with the resident for a while. At 9:30 p.m., Response			

	received at 9:30 p.m. LPN 4 indicated the daughter left by way of the resident's patio door for the night after the resident was moved to the Memory Care unit temporarily until he could be evaluated by his Neurologist on 8/27/21. A document, titled "Indiana State Department of Health Survey Report System," dated 8/25/21 and provided by the ED indicated on 8/19/21 at 2:45 p.m., Resident B left the facility to go for a walk without signing out and he ended up at a neighboring healthcare facility. He indicated to the healthcare facility he was not able to find his way back to the facility. He had a BIMS (Brief Interview Mental Status) of 15/15 and he was independent of his ADL's (Activities of Daily Living). He was picked up by the facility bus and brought back to the facility. During an interview with him, he indicated to facility staff he went for a walk and got turned around and was not able to find his way back to the facility. He was not aware he was required to sign himself out in the Leave of Absence book whenever he wanted to leave the facility. The facility staff provided the resident with education on signing out to ensure the facility knew his where about's. The preventative measures taken were he was educated on signing out when he left the			

	facility, he was placed on 15 minute checks, an outside door alarm was turned on 24 hours and seven days a week. The Elopement Reportable Guideline Tool used by the facility to check all the items had been completed after an Elopement Reportable had been filed with the appropriate authorities indicated the "Documentation" checklist section was not completed. In the "Follow Up" section, these areas not completed included, but were not limited to, Detailed time line when the resident was last visualized in the facility and when he was noted missing. There was a lack of staff interviews for the investigation of the 8/19/21 and 8/25/21 elopement incidences. Not every employee who was involved during each one of these elopements were interviewed for their witness testimony. On 8/26/21 at 12:20 p.m., the total distance driven from the facility to the (Name of the Health Care Center) Resident B walked to when he left the facility on 8/19/21 at approximately 2:45 p.m., without signing out LOA or with supervision was 0.2 miles. The total distance driven from the			

	facility to the gas station Resident B walked to on 8/25/21 at approximately 7:30 p.m., when he eloped from the facility was 0.2 miles. During a tour, on 8/26/21 at 1:55 p.m., with LPN 1 and LPN 3 in attendance, the pager system and the door alarm in Resident B's room was tested. While testing the pager system, the nurse's pager on the general AL (assisted living) side did not beep while it was sitting on one of the medication carts. LPN 1 picked up the pager off the medication cart. Then as she turned the pager on, she indicated the nurses did not have to have their pagers on their person while they were in the nurses' station because they were able to see the pages on the computer. On 8/26/21 at 2:30 p.m., Resident B was observed sitting in the lounge area when Resident C came out of her apartment, walked up to Resident B and grabbed his hands in hers. She picked up his hands into hers. He had eye brow furrowing when she first walked up to him, then as she began to talk to him he slowly relaxed his eyebrows. He began to have tears run down his face the longer Resident C stood and talked with him. During an interview, on 8/27/21			

	at 10:30 a.m., LPN 4 and the ED were in attendance. LPN 4 indicated there was no written amount of time required for the aides to answer alarms sounding on the doors, but nine minutes "was to long" to wait to check on a door alarming. PCA 7 was caring for a resident when the alarm was sounding, one of the nurses was in a resident's room because she was having breathing difficulties, the other nurse was passing medications and the CNA was with another resident. The management team had already discussed with all the nursing staff about communicating with each other when the aides were unable to answer the pagers, so everyone knew who was answering which page alert. They discussed with the nurses how they were to be carrying the pagers on their person and they had to assist the aides in answering the pages when the aides were unable to do so. When asked if nurses were expected to answer the pager calls as well, LPN 4 indicated the aides were primarily responsible for answering the pagers. The nurses were expected to help answer the pagers if able to do so and the aides could not get to the page. The nurse passing the medications should have stopped passing medications as soon as she could have and checked on Resident B's door alarm alert. The management			

	staff had already discussed this situation with that particular nurse. The record for Resident B was reviewed on 8/27/21 at 2:00 p.m. Diagnoses included, but were not limited to, mild cognitive impairment, Parkinson's disease, anxiety disorder, type 2 Diabetes Mellitus and other visual disturbances. Resident B's progress notes were reviewed, which included, but were not limited to, the following notes related to the two elopements on these dates and times: On 08/17/2021 at 1:49 p.m., the resident's daughter brought his call pendant to a staff member and indicated his call pendant did not work and this was the reason why he would not wear it. The call pendent, which was found to be in working order. On 08/18/2021 at 5:29 a.m., the nurse went to the resident's room to pass his medications for the morning and he was sitting on side of his bed. He was observed to be upset and was tearful. The resident asked where he was and indicated he was "in trouble." When asked why he had wet the bed, he then asked where his daughter was. He was assured, he was safe at the facility and his			

	daughter was fine. On 08/19/2021 at 2:30 p.m., the DON was notified the resident had been found outside off the facility grounds. The DON had previously talked with his family about taking the resident to urgent care for lab work related to increased confusion. The family did not want to have labs done STAT, at facility. The family had said someone would be there to take him. The family was notified of the resident being found confused and off the facility grounds. The resident was returned to the facility and his outside door alarm was set. On 08/19/2021 at 3:20 p.m., the facility nurse received a call from a staff member at (Name of Health Care Center)who indicated the resident was at their facility and he had come in and indicated where he lived. He was lost, confused and was trying to find his way back to the facility. The nurse notified the facility bus driver to go pick the resident up. His current BIMS (Brief Interview of Mental Status) when he arrived back at the facility was 15/15. On 8/19/21 at 3:30 p.m., LPN 4 spoke with the resident upon return to the facility. He indicated he was going up to the park on 18th and got turned around. He then stopped at			

	(Name of Health Care Center) and told the staff where he was from. They called the facility and the facility's bus driver went and picked him up. It was explained to him, he needed to sign out at the front desk. He agreed to do so. The alarm on the exterior door in this apartment was turned on 24/7 and the staff were made aware to respond if Resident B's patio door alarmed anytime. On 08/19/2021 at 3:40 p.m., Resident B's daughter was notified of him being out of facility without staff knowledge. She indicated she was at an appointment at the moment, but once she was done she would be at the facility to take the resident to urgent care. On 08/20/2021 at 7:00 a.m., the facility received a call from the resident's daughter indicating she was unable to get the resident to urgent care for the UA yesterday and asked if the facility could we please get it done at the facility when possible. On 08/20/2021 at 1:43 p.m., the UA was obtained and sent to the lab. The daughter asked if it would be ok to put a ring doorbell in the residents room, so she could monitor the resident. She was informed the resident's door had an alarm, which triggered on the facilities			

	computer and pagers. On 08/21/2021 at 7:30 a.m., the receptionist called the nurses' station and asked the nurse to come up front because Resident B was at the front of the facility wanting to walk out the front door. The resident was redirected back to his room. On 08/25/2021 at 12:55 p.m., (Recorded as a Late Entry on 08/26/2021 at 8:19 a.m.), Resident B's Physician was updated regarding the resident's confusion. The resident remained confused and believed his wife would be coming to see him. The Physician indicated the resident had not been on the antibiotic long enough yet and to continue to monitor. On 08/25/2021 at 08:22 p.m., a staff member reported to the nursing station after responding to Resident B's door alarm at 7:30 p.m. The staff member noted the resident's outside door alarm triggered at 7:26 p.m., and the resident was not observed in his room when she arrived. The resident was last observed to be in his room at 7 p.m. during the evening medication pass. Nursing staff was alerted and initiated a perimeter search. The DON (Director of Nursing) was called on the phone during the search and made aware the resident			

	was not in the building. Staff members observed the resident outside of the facility walking down the street away from the facility. The staff members were able to redirect Resident B back to the facility without concerns. The resident indicated he was "walking home." A staff member was left in the the resident's room with him for one on one supervision to monitor for safety. The resident's POA (Power of Attorney) was made aware of the resident leaving the facility and indicating he was on the way home. Due to his increased confusion, he would need to be supervised by family or a private caregiver overnight for his safety. The family could take the resident home with them overnight, he could be sent to the ER (Emergency Room) for evaluation, or he could be moved temporarily to the memory care unit. The NP (Nurse Practitioner) was made aware of the situation and she agreed with the solutions given to the POA. She was made aware the resident did not have a diagnosis of dementia and was currently on an antibiotic for a urinary tract infection. On 08/25/2021 at 9:05 p.m., the resident's POA arrived at the facility. During a phone call with LPN 10, LPN 1, LPN 3 and LPN 4 and the POA, the POA voiced concerns regarding Resident B's safety and increased			

	confusion over the past 4 days. After a discussion between all those individuals, the decision was made to move Resident B to the memory care unit temporarily overnight. On 08/26/2021 at 10:29 a.m., The resident's Physician gave a new order for Resident B to reside on the secured memory care unit until he was evaluated by his Neurologist on 8/27/21. On 08/26/2021 at 12:54 p.m., the resident came to dining room for lunch where Resident C noticed him, waved and said hi. The resident became tearful, then conversed with Resident C without any concerns observed. On 08/26/2021 at 9:58 p.m., the resident indicated to a staff member he remembered walking to the gas station yesterday (8/25/21) and two staff members brought him back to the facility. The POA indicated Resident B ate lunch and visited with Resident C this day on the memory care unit, but he did not feel comfortable being around her and he did not want to see her. The POA indicated he was still scared of Resident C. Resident B was informed the staff members would do whatever they had to do, to keep him feeling safe and protected and to ensure his privacy. During the evening, Resident C insisted she needed			

	to tell Resident B goodnight, when he came to the lounge to speak to her, she asked him to go to her room. Resident B indicated to Resident C he wanted to follow the facility rules. Both Resident B and C were informed for safety reasons the staff members needed to monitor the residents. Resident C was overheard making "demeaning comments" to Resident B "you're gonna listen to THEM instead of your WIFE?" A staff member locked Resident B's apartment door when he went to bed for the night. On 08/27/2021 at 3:48 a.m., the resident was currently staying on the secured memory care unit.			

	On 08/27/2021 at 12:11 p.m., the resident followed up with his Neurologist this morning. The daughter (POA) was informed about the conversation the facility had with the nurse for the Neurologist. It was shared with the Neurologist, the facility management felt doing the resident's cognitive testing with him while he had a UTI (urinary tract infection) might not have been a good baseline of his true cognition. The daughter indicated the Nurse Practitioner who evaluated him at the Neurologist office completed the cognitive testing with him and he passed. During an interview, on 8/27/21 at 11:08 a.m., Resident B, his daughter and son-in-law were down in a private office and given a chance to voice their concerns regarding Resident B not being allowed to stay in his apartment with the patio door anymore since his two elopements. During the conversation, on 8/27/21 at 11:42 a.m., the ED and LPN 4 came to the private office door and LPN 4 indicated to both family members she had talked with Resident B's NP about the mental status test being completed and she did not want it done with him being treated with for a UTI. This was why, she called the Neurologist office and informed them prior to him going for his Physician visit. The			

	daughter indicated the mental status test was completed at the visit and he passed with "flying colors." At this time, Resident B indicated he did not want to stay back in the Memory Care Unit with Resident C because he was afraid of her every since she threw him down the stairs at their home. Resident B indicated the first day he observed Resident C on the Memory Care unit she grabbed him by the wrists and told him to call their daughter and tell her to get Resident C out of there. The daughter indicated Resident C and Resident B could not be together on the same unit because Resident C pushed him down a flight of stairs at home prior to bringing him into the facility. Resident B indicated he was afraid of Resident C due to she was "abusive" to him. He indicated he loved her, but he could not live on the same unit as her because he was scared of what she might do to him. During the exit conference, on 8/30/21 at 5:29 p.m., while discussing the concern regarding a thorough investigation not being completed for Resident B's two elopements due a lack of staff interviews. LPN 1 indicated PCA 7 wrote a statement on 8/27/21, regarding the elopement of Resident B. The ED indicated there were no interviews written by staff regarding his			

	elopement, everything was written in the nurses' notes. LPN 1 provided a handwritten and undated statement from PCA 7. PCA 7 indicated in her hand written statement she was answering a call light and the CNA was on break. A nurse came into the room she was in to check a resident's vitals who was having some difficulties and possibly needed to go to the hospital. She was getting her ready in case she had to go to the hospital when Resident B's door alarm rang on her pager. She urgently finished getting the resident ready she was working with and ran to Resident B's room to check on him and he was not there. She went to the nurses' station where both nurses were sitting down and one of the nurses indicated she had seen Resident B 30 minutes prior when she took his medications to him. They all looked all over the building for him and could not find him. She and CNA 9 looked around outside and they found him walking close to the Circle K gas station which was approximately 0.25 miles down from the facility. Both staff members brought him back and she stayed with him until his daughter arrived. PCA 7 indicated the nurses sitting at the nurses station did not see Resident B's door alarm page because they were not wearing their pagers as they should			

	have been. 2. A document, titled "Indiana State Department of Health Survey Report System," indicated on 8/16/21 at 10:14 a.m., Resident C during a 15 minute check was found in an enclosed courtyard. The window in her apartment had been tilted in and the screen had been pushed out. A document, titled "Elopement Reportable Guidance Log," included, but was not limited to, the following information: in the "Follow Up" section the detailed timeline completed when the resident was last visualized in the facility was not documented as completed. Interviews reviewed for information needing additional action was not documented as completed to indicated a thorough investigation was completed. There was a lack of staff interviews for the investigation of Resident C's 8/16/21 elopement incidence. Not every employee who was involved during the elopement incident was interviewed for their witness testimony. The record for Resident C was reviewed on 8/27/21 at 2:45 p.m. Diagnoses include, but were not limited to, dementia without behavioral disturbance, COVID-19 acute respiratory			

	disease, hypertension and alcohol abuse. The progress notes were reviewed and included, but were not limited to, the following notes on these dates and times: On 06/30/2021 at 7:13 p.m., Resident C became agitated after supper and wanted to talk to her family. She was told her daughter was on vacation and she became very angry indicating "I've gotta get out of here. I'm gonna call the police to help me. I'm so upset with this place. You're lying to me." On 07/11/2021 at 8:42 p.m., At 7 p.m., the resident paced up and down quickly, indicating she was going to "get out of here some way. Even if I have to throw myself out the window, and climb the fence". The staff was unable to redirect, distract, or calm the resident. The resident stated she wanted to call her family and "my parents would get me out". On 07/17/2021 at 7:53 p.m., the resident was adamant to speak with her daughter and they did not have a phone number for her. Resident C indicated "I'm done with this place. I can't take it anymore. I have to leave. Just let me out the door and I'll walk. Get me out of here or I'll kill myself." The resident was ensured the staff cared about			

her. When asked if she had a plan, the resident hesitated, then indicated "well, there are ways." "If you won't help me, I'll call the police." She was found one time behind the nurses' station looking for her daughter's phone number, but denied opening the gate.

On 07/19/2021 at 4:00 p.m., the resident started asking if her husband was alive. She wanted to talk to her daughter. She was encouraged to speak with her daughter by phone, she refused at first, then indicated she would. She became agitated, indicating the facility was a terrible place with nothing to do even though she had just refused to play Bingo. She indicated "Everyone just lies." "I have to get out of here. If you bring me a gun I'll blow my F***** brains out. I can't stand being here. I'm ready to leave." She calmed down and spoke more to her daughter.

On 07/20/2021 at 7:00 p.m., After dinner Resident C spoke with her daughter a couple of times and asked to get out of the facility. After she hung up the phone, she was found at the end of the hall with the window open all the way, trying to open the screen. She indicated she was getting out of the facility. A few minutes later, she did the same thing again with the window. The resident was

	placed on 15 minute checks for her safety. The DON and Unit Manager was notified. The resident indicated after she calmed down, "I'm fine, I'm not in any danger. I just want to leave now." On 07/20/21 at 10:30 p.m., the DON indicated the resident should be on one on one observation by the family or another care giver. She spoke with the POA who indicated she nor any other care giver was coming in to do one on one supervision with the resident because this was what the facility got paid to do. It was explained to the POA this was an Assisted Living facility and they were unable to support that level of care. After conferring with the DON, PA (Physician's Assistant) and the POA regarding their options, an order was received to send Resident C to a Geri-Psych facility for emergency evaluation and treatment. On 08/10/2021 at 12:00 a.m., on 08/09/21 at 8 p.m., the resident indicated she wanted to get out of the facility and she was "tired of being here". The daughter called the facility after speaking to the resident indicating Resident C told her she was going to "scale the wall." On 08/16/2021 at 9:34 a.m.,			

during the weekend on second shift, staff reported the resident was talking of harm to herself if she could not get out of the facility. 15 minute checks were started.

On 08/16/2021 at 10:14 a.m., the writer went to do a 15 minute check on Resident C and observed her outside in the gazebo. The writer went to check her room and her window was broken and the screen was pushed out. The resident was sitting outside. She refused to come in. The ED and DON are aware.

On 08/16/2021 at 10:15 a.m., the Physician was contacted regarding the resident's noncompliance with her mask use as well as not staying in her apartment. The MD indicated she had already spoke with the resident's nurse this morning and had left a message with a psych provider for further recommendations. At that time, the provider was informed of the resident breaking a window and going out into the courtyard. The Physician indicated the resident needed to be sent out to hospital.

On 08/16/2021 at 11:00 a.m., Resident C continued to sit outside. She refused to come into the facility.

During an interview, on 8/27/21

	at 10:30 a.m., LPN 4 and the ED (Executive Director) were in attendance. LPN 4 indicated the longest amount of time Resident C would have been outside unsupervised in the secured Memory Care unit Courtyard would have been 15 minutes because she was on 15 minute checks. The CNA had checked on Resident C and she was in her room, then 15 minutes later, when the CNA went to check on her in her apartment, she was found outside in the courtyard unsupervised. Her window was tilted in and the screen was pushed out. During an interview, on 8/27/21 at 11:08 a.m., the resident's daughter (POA) indicated the first time she tried to elope from the facility, she raised the window at the end of the Memory care hallway and pushed the screen out and climbed out the window and was found around the front of the building. She did not know how true the story was because she had been told different stories. The resident's daughter indicated the second time she attempted to elope from the facility, she climbed out her window into the enclosed Memory Care courtyard. A current policy, titled "Door Alarms-Residential," dated as revised 12/17 and provided by the ED on 8/26/21 at 12:44			

	p.m., indicated "...Title: Door Alarms--Residential Care Purpose of Policy: This policy pertains to principles, rules, and guidelines formulated and adopted for this community's door alarms-residential care. Policy: This residential Community has alarmed doors leading to the outside of the building to provide a safe environment for our residents. The alarm system is activated at late evening hours to early morning that meet the needs of the Community to provide a secure environment for residents and staff members. (These hours may flex slightly). Procedure: 1. Outside doors are equipped with an alarm system to alert staff members when a door has been opened. Activate at late evening hours to early morning that meet the needs of the Community to provide a secure environment for residents and staff members (these hours may flex slightly or according to building need and as indicate by State regulations. 2. It is responsibility of all staff members to respond to each alarm...4. A staff member must go to the door(s) that have been opened to investigate the situation. When arriving at the door, the staff member should determine the cause of the alarm. If a resident has exited the building, the staff should remain with the resident until he/she returns to the			

	building...6. For procedure for 'Missing Resident', proceed to Missing Resident/Resident Elopement Policy...." A current policy, titled "Elopement (Risk and Missing Resident)," dated as revised date 10/18 and provided by the ED on 8/26/21 at 12:44 p.m., indicated "...Policy: it is the policy of this Community that staff who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken. Procedure: Residents identified to be at risk or have a history of elopement will be identified as follows: 1. Resident identified to be at risk for elopement will be identified as follows...c. Any resident identified as an "Elopement Risk' will be evaluated for the placement of an 'electronic monitoring device. Verbal exit seeking behavior such as comments or threats of leaving the building is to be considered at risk for potential elopement. d. If the community does not utilize the 'electronic monitoring device' within their community, then the nursing staff will proceed with visual safety checks until family, responsible party or companion care can be arrange...."			

This State finding relates to Complaint IN00360638.

Based on observation, interview and record review, the facility failed to ensure residents were free from neglect, related to a resident who had an elopement six days previously, to his patio door alarm sounding for at least 9 minutes prior to a staff member checking the door, another resident with a dementia diagnosis was found in the facility courtyard unsupervised and the facility failed to thoroughly investigate 2 of 3 elopements being reviewed for neglect (Residents B and C). This deficient practice resulted in Resident B feeling anxious related to being placed on the same Memory Care unit as Resident C (who was his wife) and he was afraid of her due to previous incidents, which occurred prior to their admissions to the facility.

Findings include:

1. A Confidential interview was conducted during the course of the survey. The Confidential interviewee indicated PCA 7 came into work on 8/30/21 to write her statement for Resident B's elopement off the facility grounds, which occurred on 8/25/21 and he was found down by the Circle K gas station. PCA 7 brought him back to the facility. The Confidential

	Interviewee indicated the nurses did not carry the pagers on their person to listen to the call lights or door alarms pages because it was "supposed to be" the aides responsibility to answer the page alerts. If the aides were busy, then they answered them as soon as they finished what they were doing. The Confidential Interviewee indicated she heard Resident B indicate he was scared of Resident C and he did not want to be alone with her. A typed statement, dated 8/25/21, by LPN 5 indicated she and LPN 10 were sitting at the nurses' station when PCA 7 told them Resident B was not in his apartment. She asked when he was last seen and LPN 10 indicated when she gave him his medication. All three of them went to search for him. She and LPN 10 met up outside in the front of the facility and this was when they observed Resident B walking down the street past (Name of a Health Care Center), then PCA 7 and CNA 10 both ran to get him and brought him back to the facility. During an interview, on 8/25/21 at 1:57 p.m., LPN 3 (the Floating Clinical Director acting as the Interim Director, LPN 4 (the Clinical Support Specialist) and LPN 6 (Newly hired DNS orienting) were in attendance. LPN 3 indicated Resident B left			

his apartment on 8/19/21, through his patio door without signing out LOA (leave of absence). He walked 0.2 miles going North, became confused as to where he was and went into (Name of Health Care Center). He was able to tell the staff at (Name of the Healthcare Center) the name of the facility he lived at, but was confused as how to get back home. They called the facility, then a staff member went and picked him up in the facility bus.

During an interview, on 8/26/21 at 12:44 p.m., the Executive Director (ED), LPN 1 (the Director of Clinical Services), LPN 3 and LPN 4 were in attendance. While reviewing information, which was provided by the ED regarding the elopement of Resident B on 8/19/21, a typed, unsigned interview, dated 8/25/21, with LPN 5's name typed at the bottom of the paragraph indicated Resident B had eloped again on 8/25/21. There was no date or time listed in the typed interview as to when this event occurred. The ED was asked if this interview was regarding the elopement on 8/19/21 or if Resident B had eloped a second time and she indicated the resident eloped again last night (8/25/21) at approximately 7:30 p.m., and he got down to the (Name of the Healthcare Center) he had

	walked to previously before the staff could reach him. During this time, LPN 4 printed the history of Resident B's patio door alarm alerts for 8/25/21. This document was reviewed at this time with the attendees of the interview and the following was indicated: At 9:07 a.m., Response received at 9:07 a.m. LPN 4 indicated the resident opened the door to get fresh air as he frequently did throughout the day. At 9:08 a.m., the alarm announced on the nursing staff's pagers 10 times the door was open. "This alert was never responded to." LPN 4 indicated the staff responded to the alarm, but they could not close the door to reset it because the resident was sitting in his apartment with the door open to get fresh air. LPN 4 indicated the door alarm alerted 9 times, then it sent a message indicating the door alarm was never responded to by a staff member. At 1:37 p.m., Response received at 1:37 p.m. LPN 4 indicated the resident opened his door for fresh air and was educated not to open his back patio door due to the alarm sounding. At 1:51 p.m., Response			

	received at 1:52 p.m. LPN 4 indicated the resident had the door open to get fresh air. At 4:59 p.m., Response received at 4:59 p.m. LPN 4 indicated the resident had the door open to get fresh air. At 7:25 p.m., Response received at 7:26 p.m. LPN 4 indicated the resident opened the patio door to get fresh air. At 7:30 p.m., Response received at 7:30 p.m. LPN 4 indicated the resident opened the patio door to get fresh air. At 7:33 p.m., the alarm was announced on the nursing staff's pagers 2 times. Response received at 7:42 p.m. (9 minutes later). LPN 4 indicated PCA 7 responded to the door alarm at 7:42 p.m. When she arrived to his apartment he was not in there and the door was open. She notified the nurses and the staff began to look for him and he was found down by the (Name of Health Care Center) again. At that time, the Interim DNS indicated on 8/25/21 prior to the resident leaving the facility the staff noticed Resident B's cognition was "off," so the nurse notified his daughter to get permission to order a Urinalysis (UA) to be done Stat (due to when a test was ordered Stat, there was an additional fee			

	charged to the family, so permission was needed to order the test stat). The daughter indicated she would come and take him to urgent care, but prior to getting him to urgent care for the UA test he eloped from the facility. At 8:24 p.m., Response received at 8:24 p.m. LPN 4 indicated a staff member was sitting with Resident B at this time. The patio door was opened by the resident's daughter. She sat with the resident for a while. At 9:30 p.m., Response received at 9:30 p.m. LPN 4 indicated the daughter left by way of the resident's patio door for the night after the resident was moved to the Memory Care unit temporarily until he could be evaluated by his Neurologist on 8/27/21. A document, titled "Indiana State Department of Health Survey Report System," dated 8/25/21 and provided by the ED indicated on 8/19/21 at 2:45 p.m., Resident B left the facility to go for a walk without signing out and he ended up at a neighboring healthcare facility. He indicated to the healthcare facility he was not able to find his way back to the facility. He had a BIMS (Brief Interview Mental Status) of 15/15 and he was independent of his ADL's			

	(Activities of Daily Living). He was picked up by the facility bus and brought back to the facility. During an interview with him, he indicated to facility staff he went for a walk and got turned around and was not able to find his way back to the facility. He was not aware he was required to sign himself out in the Leave of Absence book whenever he wanted to leave the facility. The facility staff provided the resident with education on signing out to ensure the facility knew his where about's. The preventative measures taken were he was educated on signing out when he left the facility, he was placed on 15 minute checks, an outside door alarm was turned on 24 hours and seven days a week. The Elopement Reportable Guideline Tool used by the facility to check all the items had been completed after an Elopement Reportable had been filed with the appropriate authorities indicated the "Documentation" checklist section was not completed. In the "Follow Up" section, these areas not completed included, but were not limited to, Detailed time line when the resident was last visualized in the facility and when he was noted missing. There was a lack of staff			

	interviews for the investigation of the 8/19/21 and 8/25/21 elopement incidences. Not every employee who was involved during each one of these elopements were interviewed for their witness testimony. On 8/26/21 at 12:20 p.m., the total distance driven from the facility to the (Name of the Health Care Center) Resident B walked to when he left the facility on 8/19/21 at approximately 2:45 p.m., without signing out LOA or with supervision was 0.2 miles. The total distance driven from the facility to the gas station Resident B walked to on 8/25/21 at approximately 7:30 p.m., when he eloped from the facility was 0.2 miles. During a tour, on 8/26/21 at 1:55 p.m., with LPN 1 and LPN 3 in attendance, the pager system and the door alarm in Resident B's room was tested. While testing the pager system, the nurse's pager on the general AL (assisted living) side did not beep while it was sitting on one of the medication carts. LPN 1 picked up the pager off the medication cart. Then as she turned the pager on, she indicated the nurses did not have to have their pagers on their person while they were in the nurses' station because they were able to see the pages on			

	the computer. On 8/26/21 at 2:30 p.m., Resident B was observed sitting in the lounge area when Resident C came out of her apartment, walked up to Resident B and grabbed his hands in hers. She picked up his hands into hers. He had eye brow furrowing when she first walked up to him, then as she began to talk to him he slowly relaxed his eyebrows. He began to have tears run down his face the longer Resident C stood and talked with him. During an interview, on 8/27/21 at 10:30 a.m., LPN 4 and the ED were in attendance. LPN 4 indicated there was no written amount of time required for the aides to answer alarms sounding on the doors, but nine minutes "was to long" to wait to check on a door alarming. PCA 7 was caring for a resident when the alarm was sounding, one of the nurses was in a resident's room because she was having breathing difficulties, the other nurse was passing medications and the CNA was with another resident. The management team had already discussed with all the nursing staff about communicating with each other when the aides were unable to answer the pagers, so everyone knew who was answering which page alert. They discussed with the nurses how they were to be			

	carrying the pagers on their person and they had to assist the aides in answering the pages when the aides were unable to do so. When asked if nurses were expected to answer the pager calls as well, LPN 4 indicated the aides were primarily responsible for answering the pagers. The nurses were expected to help answer the pagers if able to do so and the aides could not get to the page. The nurse passing the medications should have stopped passing medications as soon as she could have and checked on Resident B's door alarm alert. The management staff had already discussed this situation with that particular nurse. The record for Resident B was reviewed on 8/27/21 at 2:00 p.m. Diagnoses included, but were not limited to, mild cognitive impairment, Parkinson's disease, anxiety disorder, type 2 Diabetes Mellitus and other visual disturbances. Resident B's progress notes were reviewed, which included, but were not limited to, the following notes related to the two elopements on these dates and times: On 08/17/2021 at 1:49 p.m., the resident's daughter brought his call pendant to a staff member			

	and indicated his call pendant did not work and this was the reason why he would not wear it. The call pendent, which was found to be in working order. On 08/18/2021 at 5:29 a.m., the nurse went to the resident's room to pass his medications for the morning and he was sitting on side of his bed. He was observed to be upset and was tearful. The resident asked where he was and indicated he was "in trouble." When asked why he had wet the bed, he then asked where his daughter was. He was assured, he was safe at the facility and his daughter was fine. On 08/19/2021 at 2:30 p.m., the DON was notified the resident had been found outside off the facility grounds. The DON had previously talked with his family about taking the resident to urgent care for lab work related to increased confusion. The family did not want to have labs done STAT, at facility. The family had said someone would be there to take him. The family was notified of the resident being found confused and off the facility grounds. The resident was returned to the facility and his outside door alarm was set. On 08/19/2021 at 3:20 p.m., the facility nurse received a call from a staff member at (Name			

	of Health Care Center)who indicated the resident was at their facility and he had come in and indicated where he lived. He was lost, confused and was trying to find his way back to the facility. The nurse notified the facility bus driver to go pick the resident up. His current BIMS (Brief Interview of Mental Status) when he arrived back at the facility was 15/15. On 8/19/21 at 3:30 p.m., LPN 4 spoke with the resident upon return to the facility. He indicated he was going up to the park on 18th and got turned around. He then stopped at (Name of Health Care Center) and told the staff where he was from. They called the facility and the facility's bus driver went and picked him up. It was explained to him, he needed to sign out at the front desk. He agreed to do so. The alarm on the exterior door in this apartment was turned on 24/7 and the staff were made aware to respond if Resident B's patio door alarmed anytime. On 08/19/2021 at 3:40 p.m., Resident B's daughter was notified of him being out of facility without staff knowledge. She indicated she was at an appointment at the moment, but once she was done she would be at the facility to take the resident to urgent care.			

	On 08/20/2021 at 7:00 a.m., the facility received a call from the resident's daughter indicating she was unable to get the resident to urgent care for the UA yesterday and asked if the facility could we please get it done at the facility when possible. On 08/20/2021 at 1:43 p.m., the UA was obtained and sent to the lab. The daughter asked if it would be ok to put a ring doorbell in the residents room, so she could monitor the resident. She was informed the resident's door had an alarm, which triggered on the facilities computer and pagers. On 08/21/2021 at 7:30 a.m., the receptionist called the nurses' station and asked the nurse to come up front because Resident B was at the front of the facility wanting to walk out the front door. The resident was redirected back to his room.			

	On 08/25/2021 at 12:55 p.m., (Recorded as a Late Entry on 08/26/2021 at 8:19 a.m.), Resident B's Physician was updated regarding the resident's confusion. The resident remained confused and believed his wife would be coming to see him. The Physician indicated the resident had not been on the antibiotic long enough yet and to continue to monitor. On 08/25/2021 at 08:22 p.m., a staff member reported to the nursing station after responding to Resident B's door alarm at 7:30 p.m. The staff member noted the resident's outside door alarm triggered at 7:26 p.m., and the resident was not observed in his room when she arrived. The resident was last observed to be in his room at 7 p.m. during the evening medication pass. Nursing staff was alerted and initiated a perimeter search. The DON (Director of Nursing) was called on the phone during the search and made aware the resident was not in the building. Staff members observed the resident outside of the facility walking down the street away from the facility. The staff members were able to redirect Resident B back to the facility without concerns. The resident indicated he was "walking home." A staff member was left in the the resident's room with him for one on one			

	supervision to monitor for safety. The resident's POA (Power of Attorney) was made aware of the resident leaving the facility and indicating he was on the way home. Due to his increased confusion, he would need to be supervised by family or a private caregiver overnight for his safety. The family could take the resident home with them overnight, he could be sent to the ER (Emergency Room) for evaluation, or he could be moved temporarily to the memory care unit. The NP (Nurse Practitioner) was made aware of the situation and she agreed with the solutions given to the POA. She was made aware the resident did not have a diagnosis of dementia and was currently on an antibiotic for a urinary tract infection. On 08/25/2021 at 9:05 p.m., the resident's POA arrived at the facility. During a phone call with LPN 10, LPN 1, LPN 3 and LPN 4 and the POA, the POA voiced concerns regarding Resident B's safety and increased confusion over the past 4 days. After a discussion between all those individuals, the decision was made to move Resident B to the memory care unit temporarily overnight. On 08/26/2021 at 10:29 a.m., The resident's Physician gave a new order for Resident B to reside on the secured memory			

	care unit until he was evaluated by his Neurologist on 8/27/21. On 08/26/2021 at 12:54 p.m., the resident came to dining room for lunch where Resident C noticed him, waved and said hi. The resident became tearful, then conversed with Resident C without any concerns observed. On 08/26/2021 at 9:58 p.m., the resident indicated to a staff member he remembered walking to the gas station yesterday (8/25/21) and two staff members brought him back to the facility. The POA indicated Resident B ate lunch and visited with Resident C this day on the memory care unit, but he did not feel comfortable being around her and he did not want to see her. The POA indicated he was still scared of Resident C. Resident B was informed the staff members would do whatever they had to do, to keep him feeling safe and protected and to ensure his privacy. During the evening, Resident C insisted she needed to tell Resident B goodnight, when he came to the lounge to speak to her, she asked him to go to her room. Resident B indicated to Resident C he wanted to follow the facility rules. Both Resident B and C were informed for safety reasons the staff members needed to monitor the residents. Resident C was overheard			

	making "demeaning comments" to Resident B "you're gonna listen to THEM instead of your WIFE?" A staff member locked Resident B's apartment door when he went to bed for the night. On 08/27/2021 at 3:48 a.m., the resident was currently staying on the secured memory care unit. On 08/27/2021 at 12:11 p.m., the resident followed up with his Neurologist this morning. The daughter (POA) was informed about the conversation the facility had with the nurse for the Neurologist. It was shared with the Neurologist, the facility management felt doing the resident's cognitive testing with him while he had a UTI (urinary tract infection) might not have been a good baseline of his true cognition. The daughter indicated the Nurse Practitioner who evaluated him at the Neurologist office completed the cognitive testing with him and he passed. During an interview, on 8/27/21 at 11:08 a.m., Resident B, his daughter and son-in-law were down in a private office and given a chance to voice their concerns regarding Resident B not being allowed to stay in his apartment with the patio door anymore since his two elopements. During the			

	conversation, on 8/27/21 at 11:42 a.m., the ED and LPN 4 came to the private office door and LPN 4 indicated to both family members she had talked with Resident B's NP about the mental status test being completed and she did not want it done with him being treated with for a UTI. This was why, she called the Neurologist office and informed them prior to him going for his Physician visit. The daughter indicated the mental status test was completed at the visit and he passed with "flying colors." At this time, Resident B indicated he did not want to stay back in the Memory Care Unit with Resident C because he was afraid of her every since she threw him down the stairs at their home. Resident B indicated the first day he observed Resident C on the Memory Care unit she grabbed him by the wrists and told him to call their daughter and tell her to get Resident C out of there. The daughter indicated Resident C and Resident B could not be together on the same unit because Resident C pushed him down a flight of stairs at home prior to bringing him into the facility. Resident B indicated he was afraid of Resident C due to she was "abusive" to him. He indicated he loved her, but he could not live on the same unit as her because he was scared of what she might do to him.			

	During the exit conference, on 8/30/21 at 5:29 p.m., while discussing the concern regarding a thorough investigation not being completed for Resident B's two elopements due a lack of staff interviews. LPN 1 indicated PCA 7 wrote a statement on 8/27/21, regarding the elopement of Resident B. The ED indicated there were no interviews written by staff regarding his elopement, everything was written in the nurses' notes. LPN 1 provided a handwritten and undated statement from PCA 7. PCA 7 indicated in her hand written statement she was answering a call light and the CNA was on break. A nurse came into the room she was in to check a resident's vitals who was having some difficulties and possibly needed to go to the hospital. She was getting her ready in case she had to go to the hospital when Resident B's door alarm rang on her pager. She urgently finished getting the resident ready she was working with and ran to Resident B's room to check on him and he was not there. She went to the nurses' station where both nurses were sitting down and one of the nurses indicated she had seen Resident B 30 minutes prior when she took his medications to him. They all looked all over the building for him and could not find him. She and CNA 9 looked around			

	outside and they found him walking close to the Circle K gas station which was approximately 0.25 miles down from the facility. Both staff members brought him back and she stayed with him until his daughter arrived. PCA 7 indicated the nurses sitting at the nurses station did not see Resident B's door alarm page because they were not wearing their pagers as they should have been. 2. A document, titled "Indiana State Department of Health Survey Report System," indicated on 8/16/21 at 10:14 a.m., Resident C during a 15 minute check was found in an enclosed courtyard. The window in her apartment had been tilted in and the screen had been pushed out. A document, titled "Elopement Reportable Guidance Log," included, but was not limited to, the following information: in the "Follow Up" section the detailed timeline completed when the resident was last visualized in the facility was not documented as completed. Interviews reviewed for information needing additional action was not documented as completed to indicated a thorough investigation was completed. There was a lack of staff interviews for the investigation			

	of Resident C's 8/16/21 elopement incidence. Not every employee who was involved during the elopement incident was interviewed for their witness testimony. The record for Resident C was reviewed on 8/27/21 at 2:45 p.m. Diagnoses include, but were not limited to, dementia without behavioral disturbance, COVID-19 acute respiratory disease, hypertension and alcohol abuse. The progress notes were reviewed and included, but were not limited to, the following notes on these dates and times: On 06/30/2021 at 7:13 p.m., Resident C became agitated after supper and wanted to talk to her family. She was told her daughter was on vacation and she became very angry indicating "I've gotta get out of here. I'm gonna call the police to help me. I'm so upset with this place. You're lying to me." On 07/11/2021 at 8:42 p.m., At 7 p.m., the resident paced up and down quickly, indicating she was going to "get out of here some way. Even if I have to throw myself out the window, and climb the fence". The staff was unable to redirect, distract, or calm the resident. The resident stated she wanted to call her family and "my parents			

would get me out".

On 07/17/2021 at 7:53 p.m., the resident was adamant to speak with her daughter and they did not have a phone number for her. Resident C indicated "I'm done with this place. I can't take it anymore. I have to leave. Just let me out the door and I'll walk. Get me out of here or I'll kill myself." The resident was ensured the staff cared about her. When asked if she had a plan, the resident hesitated, then indicated "well, there are ways." "If you won't help me, I'll call the police." She was found one time behind the nurses' station looking for her daughter's phone number, but denied opening the gate.

On 07/19/2021 at 4:00 p.m., the resident started asking if her husband was alive. She wanted to talk to her daughter. She was encouraged to speak with her daughter by phone, she refused at first, then indicated she would. She became agitated, indicating the facility was a terrible place with nothing to do even though she had just refused to play Bingo. She indicated "Everyone just lies." "I have to get out of here. If you bring me a gun I'll blow my F***** brains out. I can't stand being here. I'm ready to leave." She calmed down and spoke more to her daughter.

	On 07/20/2021 at 7:00 p.m., After dinner Resident C spoke with her daughter a couple of times and asked to get out of the facility. After she hung up the phone, she was found at the end of the hall with the window open all the way, trying to open the screen. She indicated she was getting out of the facility. A few minutes later, she did the same thing again with the window. The resident was placed on 15 minute checks for her safety. The DON and Unit Manager was notified. The resident indicated after she calmed down, "I'm fine, I'm not in any danger. I just want to leave now."			

	On 07/20/21 at 10:30 p.m., the DON indicated the resident should be on one on one observation by the family or another care giver. She spoke with the POA who indicated she nor any other care giver was coming in to do one on one supervision with the resident because this was what the facility got paid to do. It was explained to the POA this was an Assisted Living facility and they were unable to support that level of care. After conferring with the DON, PA (Physician's Assistant) and the POA regarding their options, an order was received to send Resident C to a Geri-Psych facility for emergency evaluation and treatment. On 08/10/2021 at 12:00 a.m., on 08/09/21 at 8 p.m., the resident indicated she wanted to get out of the facility and she was "tired of being here". The daughter called the facility after speaking to the resident indicating Resident C told her she was going to "scale the wall." On 08/16/2021 at 9:34 a.m., during the weekend on second shift, staff reported the resident was talking of harm to herself if she could not get out of the facility. 15 minute checks were started. On 08/16/2021 at 10:14 a.m.,			

	the writer went to do a 15 minute check on Resident C and observed her outside in the gazebo. The writer went to check her room and her window was broken and the screen was pushed out. The resident was sitting outside. She refused to come in. The ED and DON are aware. On 08/16/2021 at 10:15 a.m., the Physician was contacted regarding the resident's noncompliance with her mask use as well as not staying in her apartment. The MD indicated she had already spoke with the resident's nurse this morning and had left a message with a psych provider for further recommendations. At that time, the provider was informed of the resident breaking a window and going out into the courtyard. The Physician indicated the resident needed to be sent out to hospital. On 08/16/2021 at 11:00 a.m., Resident C continued to sit outside. She refused to come into the facility. During an interview, on 8/27/21 at 10:30 a.m., LPN 4 and the ED (Executive Director) were in attendance. LPN 4 indicated the longest amount of time Resident C would have been outside unsupervised in the secured Memory Care unit Courtyard would have been 15 minutes			

	because she was on 15 minute checks. The CNA had checked on Resident C and she was in her room, then 15 minutes later, when the CNA went to check on her in her apartment, she was found outside in the courtyard unsupervised. Her window was tilted in and the screen was pushed out. During an interview, on 8/27/21 at 11:08 a.m., the resident's daughter (POA) indicated the first time she tried to elope from the facility, she raised the window at the end of the Memory care hallway and pushed the screen out and climbed out the window and was found around the front of the building. She did not know how true the story was because she had been told different stories. The resident's daughter indicated the second time she attempted to elope from the facility, she climbed out her window into the enclosed Memory Care courtyard. A current policy, titled "Door Alarms-Residential," dated as revised 12/17 and provided by the ED on 8/26/21 at 12:44 p.m., indicated "...Title: Door Alarms--Residential Care Purpose of Policy: This policy pertains to principles, rules, and guidelines formulated and adopted for this community's door alarms-residential care. Policy: This residential			

	Community has alarmed doors leading to the outside of the building to provide a safe environment for our residents. The alarm system is activated at late evening hours to early morning that meet the needs of the Community to provide a secure environment for residents and staff members. (These hours may flex slightly). Procedure: 1. Outside doors are equipped with an alarm system to alert staff members when a door has been opened. Activate at late evening hours to early morning that meet the needs of the Community to provide a secure environment for residents and staff members (these hours may flex slightly or according to building need and as indicate by State regulations. 2. It is responsibility of all staff members to respond to each alarm...4. A staff member must go to the door(s) that have been opened to investigate the situation. When arriving at the door, the staff member should determine the cause of the alarm. If a resident has exited the building, the staff should remain with the resident until he/she returns to the building...6. For procedure for 'Missing Resident', proceed to Missing Resident/Resident Elopement Policy...." A current policy, titled "Elopement (Risk and Missing Resident)," dated as revised			

	date 10/18 and provided by the ED on 8/26/21 at 12:44 p.m., indicated "...Policy: it is the policy of this Community that staff who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken. Procedure: Residents identified to be at risk or have a history of elopement will be identified as follows: 1. Resident identified to be at risk for elopement will be identified as follows...c. Any resident identified as an "Elopement Risk' will be evaluated for the placement of an 'electronic monitoring device. Verbal exit seeking behavior such as comments or threats of leaving the building is to be considered at risk for potential elopement. d. If the community does not utilize the 'electronic monitoring device' within their community, then the nursing staff will proceed with visual safety checks until family, responsible party or companion care can be arrange...." This State finding relates to Complaint IN00360638.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following:	R 0407	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B's	09/21/2021

(1) A system that enables the facility to analyze patterns of known infectious symptoms.

(2) Provides orientation and in-service education on infection prevention and control, including universal precautions.

(3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.

(4) Reporting communicable disease to public health authorities.

Based on interview and record review, the facility failed to ensure all visitors were being screened for the COVID-19 virus as they entered the facility. This deficient practice had the potential to affect 85 of 85 residents living in the facility.

Finding includes:

During an interview, on 8/26/21 at 12:44 p.m., the Executive Director (ED), LPN 1 (the Director of Clinical Services), LPN 3 and LPN 4 were in attendance. LPN 4 indicated on 8/25/21 at 8:24 p.m., a staff member was sitting with Resident B. The patio door was opened by the resident's daughter. She sat with the resident for a while. At this time, the question was asked if Resident B's daughter was getting screened for COVID-19 prior to entering the facility. The

family provided education regarding ensuring Residents are being screen for COVID-19 as they enter the facility; can not enter thru a patio door.

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 residents have the potential to be affected. Residents and families were provided education and information related to the need to be screened for COVID-19 upon entrance to the facility on 9/9/21 and 9/15/21. A Stop/Alert sign was posted on the outside of all patio doors to help ensure visitors go thru the front entrance and be screened for COVID19 prior to their visits.
What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Staff re-educated by 9/13/21 on COVID-19 screening policy, including but not limited to employees and all visitors must enter thru the front entrance and complete screening for COVID-19 prior to work/visitation, as well as any noncompliance should be brought to attention of

	ED indicated she and LPN 3 had discussed with her to enter the facility through the front door to enable her to get screened for COVID-19, but she continued to enter the facility by way of the resident's patio door because it was "more convenient" for her. The ED indicated Resident B's daughter entered the facility when she came to visit or pick him up for an outing through his patio door and she did not get screened in and this had been happening since he was admitted to the facility. The ED indicated she had not documented any of the times she or LPN 3 educated Resident B's daughter regarding entering the facility through the front entrance. During an interview on 8/27/21 at 11:08 a.m., Resident B, his daughter and son-in-law were sat down in a private office and given a chance to voice their concerns regarding Resident B not being allowed to stay in his apartment with the patio door anymore since his two elopements. The Daughter and Son In Law both indicated they have "always" used Resident B's patio door to enter and exit the facility and no facility staff had told them otherwise. The ED or LPN 3 had not told them they had to use the front entrance doors to get screened into the facility or Resident B had to be signed out to go LOA,		Executive Director. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? CQI tool will be initiated by 9/18/21 as monitoring tools. The Visitation during a Public Health Emergency CQI tool will be completed by the Executive Director /designee weekly x 6 weeks, then monthly until compliance is maintained for 6 consecutive months. If threshold of 100% is not met, the results will be reviewed by the IDT team and an action plan will be developed and/or disciplinary action and re-education for visitors and Residents. Date the systemic changes will be completed; All systemic changes will be completed by 9/21/21	

or they would have been following by the rules all along. The Son-In-Law indicated when he delivered groceries to the resident's apartment many times a staff member would be in the resident's room and all he was told by staff members were "What we don't see, we don't know about," so he did not know he could not enter and exit through the patio door. During the interview, on 8/27/21 at 11:42 a.m., the ED and LPN 4 came to the private office door. The daughter then told both LPN 4 and the ED she was not aware they had to go through the main entrance to be screened prior to entering the facility. The ED did not indicate to the daughter nor to her husband that either one of them had been educated by herself or another staff member in the facility regarding both of them needing to be be screened prior to entering the facility.

A current policy, titled "Infection Control and Prevention," dated as revised 12/17 and provided by the ED on 8/26/21 at 12:44 p.m., indicated "...Purpose of Policy: This policy pertains to principles, rules and guidelines formulated and adopted for this community's Infection control and prevention policy...Goals: The goals of the infection control and prevention program are to: Decrease the risk of infection to residents through

investigation and surveillance...Maintain compliance with state and federal regulations related to infection control and prevention."

This State finding relates to Complaint IN00360972.

Based on interview and record review, the facility failed to ensure all visitors were being screened for the COVID-19 virus as they entered the facility. This deficient practice had the potential to affect 85 of 85 residents living in the facility.

Finding includes:

During an interview, on 8/26/21 at 12:44 p.m., the Executive Director (ED), LPN 1 (the Director of Clinical Services), LPN 3 and LPN 4 were in attendance. LPN 4 indicated on 8/25/21 at 8:24 p.m., a staff member was sitting with Resident B. The patio door was opened by the resident's daughter. She sat with the resident for a while. At this time, the question was asked if Resident B's daughter was getting screened for COVID-19 prior to entering the facility. The ED indicated she and LPN 3 had discussed with her to enter the facility through the front door to enable her to get screened for COVID-19, but she continued to enter the facility by

way of the resident's patio door because it was "more convenient" for her. The ED indicated Resident B's daughter entered the facility when she came to visit or pick him up for an outing through his patio door and she did not get screened in and this had been happening since he was admitted to the facility. The ED indicated she had not documented any of the times she or LPN 3 educated Resident B's daughter regarding entering the facility through the front entrance.

During an interview on 8/27/21 at 11:08 a.m., Resident B, his daughter and son-in-law were sat down in a private office and given a chance to voice their concerns regarding Resident B not being allowed to stay in his apartment with the patio door anymore since his two elopements. The Daughter and Son In Law both indicated they have "always" used Resident B's patio door to enter and exit the facility and no facility staff had told them otherwise. The ED or LPN 3 had not told them they had to use the front entrance doors to get screened into the facility or Resident B had to be signed out to go LOA, or they would have been following by the rules all along. The Son-In-Law indicated when he delivered groceries to the resident's apartment many times a staff member would be

	in the resident's room and all he was told by staff members were "What we don't see, we don't know about," so he did not know he could not enter and exit through the patio door. During the interview, on 8/27/21 at 11:42 a.m., the ED and LPN 4 came to the private office door. The daughter then told both LPN 4 and the ED she was not aware they had to go through the main entrance to be screened prior to entering the facility. The ED did not indicate to the daughter nor to her husband that either one of them had been educated by herself or another staff member in the facility regarding both of them needing to be be screened prior to entering the facility.			

	A current policy, titled "Infection Control and Prevention," dated as revised 12/17 and provided by the ED on 8/26/21 at 12:44 p.m., indicated "...Purpose of Policy: This policy pertains to principles, rules and guidelines formulated and adopted for this community's Infection control and prevention policy...Goals: The goals of the infection control and prevention program are to: Decrease the risk of infection to residents through investigation and surveillance...Maintain compliance with state and federal regulations related to infection control and prevention." This State finding relates to Complaint IN00360972.			

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