STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/15/2021

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 a Post Survey Revisit (PSR) to the Investigation of Complaints IN00360638 and IN00360972 completed on August 30, 2021. This visit was in conjunction with a PSR to the Investigation of Complaint IN00361531 completed on September 8, 2021. This visit was in conjunction with a COVID-19 Quality Assurance Walk Through Survey. Complaint IN00360638 - Not corrected Complaint IN00360972 - Corrected Complaint IN00361531 - Not corrected Survey dates: November 12 and 15, 2021 Facility number: 013045	R 0000		

	Residential Census: 136 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quailty review was completed on November 23, 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 a resident with a diagnosis of dementia, was free from neglect, when the resident exited the facility through an unarmed exit door and was outside in the late night hours for an undetermined amount of time, for 1 of 4 residents being reviewed for neglect (Resident E). This deficient practice resulted in Resident E ambulating with her walker outside around the facility grounds, at approximately 10:30	R 0052	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Counseling/disciplinary action provided to staff in relation to door alarm policy, and elopement. Resident remains on 15 minute checks until she moves to secured memory care of responsible party/resident choice. 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 by this deficient practice. All staff were re-educated by 1/8/21 on door alarm response, safety, and the elopement policy. All doors checked for proper latching, alarm function. 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 staff were re-educated by 12/8/21 on door alarm response, safety, and elopement policy. All doors will be checked at least once daily for proper lock function. How the corrective actions(s) will	12/13/2021

	p.m., for an undetermined amount of time. Finding includes: A document, titled "Indiana State Department of Health Survey Report System," dated 11/15/21 at 9:15 a.m., provided by the ED (Executive Director) on 11/15/21 at 1:45 p.m., indicated "...on 11/11/21 at 11:01 p.m., [Name of Resident]...a nurse was leaving for the night and noticed resident at the front door. She was redirected to her apartment...Resident was asked why she was outside and she said she didn't know...This was a matter of minutes...Preventative Measures Taken...11/12/21-Receptionist will test doors to determine they are armed 30 minutes before clocking out daily...." The record for Resident E was reviewed on 11/15/21 at 4:00 p.m. Diagnoses included, but were not limited to, dementia, acute respiratory distress, atrial fibrillation, osteoporosis and other chronic pain. A progress note, dated 11/11/21 at 10:43 a.m., recorded as a late entry on 11/12/21 at 1:45 a.m., indicated the resident was found outside the facility by a staff member. She was fully clothed without a coat on.		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: All doors will be checked at least once daily for proper lock function and log completed by Guest Relations/designee and monitored for compliance by Executive Director/designee. If 100% threshold not met, disciplinary action and new action plan will be completed.	

The resident's Brief Interview for Mental Status (BIMS), dated 11/12/21, was a 2 out of 15, which indicated her cognitive status was severely impaired.

During an interview, on 11/15/21 at 1:30 p.m., the ED indicated Resident E had exited the facility on 11/11/21 at approximately 11:00 p.m., through a side door exit. She was discovered outside, at the front door, as a nurse was leaving to go home and was brought back into the facility without any injuries. The door was checked by the company remotely and fixed. Staff indicated the door was not alarmed, so they did not receive a page when the resident exited the facility through Door 17.

A document, titled "History of Smartcare," dated 11/12/21 at 10:24 a.m., indicated Door 17 was opened on the night shift (10:00 p.m. to 6:00 a.m.) on 11/11/21 at the following times: 10:31 p.m., 10:43 p.m., 10:48 p.m., 10:52 p.m., and 10:56 p.m. This same document indicated the front door had been opened on 11/11/21 at 11:04 p.m. and 11:08 p.m.

During an interview, on 11/15/21 at 1:45 p.m., the ED indicated Resident E exited the facility through Door 17 on 11/11/21 between 10:31 p.m. and 10:56 p.m. It was difficult for him to

determine at which one of these times she exited the facility because the staff used Door 17 to exit the facility to go home, even though they had been educated and there was a sign posted on the door to remind them the door was only to be used as an emergency exit. Door 17 was not alarmed that particular night, so when the resident pushed on the door bar, it opened and she was able to exit. The alarm did not sound as it was supposed to because someone had been moving furniture into a resident's apartment and disarmed the door. The alarm did not get turned back on allowing Resident E to exit the facility due to the door being unarmed (unlocked). The alarm did not get triggered to the staff's pagers to notify them Door 17 had been opened by Resident E because the alarm for the door was not turned on. The Director of Nursing (DON) called the alarm company and they fixed the alarm remotely.

A facility typed interview by email, undated, indicated RN 2 clocked out on 11/11/21 at 10:41 p.m., exiting through Door 17 to her car, which was parked in the front of the building. After she got into her car, she looked over towards the main entrance and saw Resident E standing outside the facility, with her walker, without a coat on and it

was approximately 42 degrees outside, according to the weather channel app she had on her phone. The resident was knocking and tapping on the front door trying to get into the facility. When RN 2 asked the resident how she got outside, she indicated she came out the door down there as she pointed to Door 17. RN 2 brought Resident E back into the facility through the main entrance and brought her to the nurses' station. She was alert, but confused as this was her baseline. She was not aware the door alarm on Door 17 had been disarmed. RN 2 indicated after looking back in the security system, there had been no alarm at any time for the door. The resident made an attempt to go out the front door back in August when she was found between the front doors in the foyer. The resident had a history of wandering the halls at night and had been found sitting in the dining room in the dark in the past also. She thought the resident had a BIMS score between 6-8.

A facility typed interview, undated, indicated Nurse 6 received a call from RN 2 around 10:48 p.m., indicating there was a resident outside the doors trying to get back inside the facility. The resident was Resident E. Nurse 6 checked the history on the computer and

there was nothing on the computer for the door. Resident E indicated to RN 2 she went out Door 17. The alarm was disarmed and the door could just be pushed open. Nurse 6 attempted to lock the door with the code she had, but it would not lock. She received the alarm code, then went to reset the door.

During an observation, on 11/15/2021 at 2:00 p.m., Resident E was standing outside her apartment throwing trash away into the three drawer isolation compartment container sitting outside her door.

During a continuous observation, on 11/15/21 from 2:02 p.m. to 2:07 p.m.,

On 11/15/21 at 2:02 p.m., a note indicated Door 17 was not to be used as an exit door, only the front door was to be used to exit the facility. Door 17 was only to be used as an emergency exit. The DON was observed disarming Door 17 by pushing the code for the door into the keypad, which unlocked the door to allow the DON to open the door. As soon as the door closed on its own, the alarm pad armed itself and the door was armed again. The DON was unable to open the locked door. The DON's pager was observed and showed Door 17 as being triggered as opened

and required a staff member to check it. The DON indicated all staff members were to be carrying pagers, but this was the change of shift just as it had been on the night shift Resident E exited the facility.

On 11/15/21 at 2:07 p.m., there had not been any staff members who came to Door 17 to check to see if a resident exited the facility. At that time, the DON indicated all staff members including the nurses were supposed to carry the pagers and walkie talkies. Anyone with a pager should have come to answer the Door 17 page. She checked all the pagers after Resident E exited the building and she knew they were all working, so she did not know why someone did not respond to the page.

On 11/15/21 at 2:08 p.m., there were five staff members in the nurses' station (evening shift) who were all staff coming on at 2:00 p.m., and were waiting for the staff to give them report. None of them had a pager on their person. There was one pager sitting on the nurses station desk, which had Door 17 being opened at 2:02 p.m., page on it. None of the five staff members in the nurses' station had checked the pager to determine why it went off. The present staff (dayshift) members were not in the nurses' station at

that time.

During an interview, on 11/15/21 at 4:11 p.m., RN 2 indicated she worked on 11/11/21 and clocked out at 10:41 p.m. She exited Door 17 and went to her car, which was parked in the front of the facility. She put the code into Door 17 to open it, but she did not know at that time, the door was unarmed. She noticed when she opened the door it was slightly ajar but at that time, she did not wonder why it was ajar. She sat down in her car and looked up at the front door and observed Resident E with her walker. She was standing there fully dressed, with shoes on, tapping and knocking on the front door trying to get into the facility. She went through the front door with the resident and took her back to the nurses' station. She found Nurse 6 and explained what happened and together they went to look at Door 17. The door was disarmed. Nurse 6 looked at her pager and discovered when the door was opened it did not trigger a page over the pager. No one knew when she went out the door. RN 2 indicated Resident E wandered the halls all night long. Late one evening, a while back in August, Resident E got "stuck" between the two front doors when she tried to exit the facility because she could not remember how to open the

inside front door to get back inside the facility. Staff members had been saying something needed to be done with her wandering around the facility.

A current facility policy, titled "Door Alarms Residential Care," dated as revised on 01/08 and provided by the ED on 11/15/21 at 4:15 p.m., indicated "Policy: The 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. A staff member working in the evening should be designated to activate the alarm system as Community management designates. A staff member working the a.m. shift should be designated to deactivate the alarm at approximately 7:30 a.m. 3. It is responsibility of all

staff members to respond to each alarm...6. 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...8. For procedure for 'Missing Resident', proceed to Missing Resident/Resident Elopement Policy."

A current facility policy, titled "Elopement (Risk and Missing Resident)," dated as revised on 10/18 and provided by the ED on 11/15/21 at 4:15 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 deficiency was cited on 8/30/21 and 9/8/21. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on observation, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia, was free from neglect, when the resident exited the facility through an unarmed exit door and was outside in the late night hours for an undetermined amount of time, for 1 of 4 residents being reviewed for neglect (Resident E). This deficient practice resulted in Resident E ambulating with her walker outside around the facility grounds, at approximately 10:30 p.m., for an undetermined amount of time.

Finding includes:

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resident pushed on the door bar, it opened and she was able to exit. The alarm did not sound as it was supposed to because someone had been moving furniture into a resident's apartment and disarmed the door. The alarm did not get turned back on allowing Resident E to exit the facility due to the door being unarmed (unlocked). The alarm did not get triggered to the staff's pagers to notify them Door 17 had been opened by Resident E because the alarm for the door was not turned on. The Director of Nursing (DON) called the alarm company and they fixed the alarm remotely.

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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