| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 09/08/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaint IN00361531.<br><br>Complaint IN00361531 -Substantiated. State deficiency related to the allegations is cited at R52 and R86.<br><br>Survey dates: September 8, 2021<br><br>Facility number: 013045<br><br>Residential Census: 96<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on September 16, 2021. | R 0000 | | |
| R 0052 | Residents' Rights - Offense<br><br>410 IAC 16.2-5-1.2(v)(1-6)<br><br>(v) Residents have the right to be free from: | R 0052 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D completed | 10/07/2021 |

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| | (1) sexual abuse;<br><br>(2) physical abuse;<br><br>(3) mental abuse;<br><br>(4) corporal punishment;<br><br>(5) neglect; and<br><br>(6) involuntary seclusion.<br><br>Based on observation, interview and record review, the facility failed to ensure a resident who was at risk for elopement was free from neglect, when she left her apartment in the middle of the night and wandered around the facility grounds, staff failed to respond to the patio door alarm, and failed to report the event to administration staff and the Indiana Department of Health (IDOH) for 1 of 1 resident being reviewed for neglect during an elopement event. (Resident D)<br><br>Findings include:<br><br>An "Intake Information" document, dated 8/31/21, provided by ISDH (Indiana State Department of Health) on 8/31/21 at 8:32 p.m., indicated an elopement event involving a resident occurred on 8/29/21 at 3:01 a.m. The event was reported to the ISDH gateway (reporting system for unusual occurrences) on 8/30/21 at 8:47 p.m. | | treatment for urinary tract infection. Resident's patio door alarm tested for proper function and alarmed 24 hours/day. Safety knob placed on Resident's patio door to aide in her recall not to go out patio door. Service plan reviewed and increased to include escorts to and from meals 9/21/21.<br><br>How the<br>facility will identify other residents having the potential to be affected by<br>the same deficient practice and what corrective action will be taken? All residents have the potential to be<br>affected. Residents with exterior patios<br>had new elopement risk assessments completed on 9/2/2021. All patio door alarms were tested to ensure<br>24 hour alert on 8/30/21. Call system<br>provider reviewed all alarms and pagers; verified operations on site on<br>9/16/21.Staff re-educated by 9/13/21, including QMA 5, on Elopement Policy and door alarms, including but not limited to immediate response to door alarms, investigation of the situation, and interviews/statements, and immediate reporting. New hire orientation to include door alarm response skills validation.Followup staff education by 10/4/21 including but not limited to Abuse Policy, Elopement Policy and door alarms, investigation, and reporting to | |

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| | During an interview, on 9/8/21 at 2:35 p.m., with the ED (Executive Director), LPN 2 and LPN 3 in attendance, LPN 2 indicated Resident D ambulated out the patio door of her apartment. QMA 5 went out to her car at approximately 3:00 a.m. on 8/29/21, and she noticed Resident D ambulating on the sidewalk in front of the facility (which faced the west side of the building) dressed in her robe and pajamas. She indicated Resident D's apartment faced the North side of the building. She was outside for an undetermined amount of time. LPN 2 indicated Resident D told QMA 5 she was waiting for a ride. The resident was confused off and on and her current BIMS (Brief Interview Mental Status) was 12 out of 15 (indicated she had a mild cognitive impairment). The ED indicated every resident's patio door was alarmed from 8:00 p.m., until 7:00 a.m., as a safety measure. When asked who responded to the alarm from Resident D's patio door, the ED indicated she was not sure anyone responded to the sounding patio door alarm.<br><br>Resident D's record was reviewed on 9/8/21 at 4:00 p.m. Diagnoses included, but were not limited to, asthma, edema in legs, osteopenia, and coronary artery disease. | | administration and the Indiana State Department of Health per policy.<br><br>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? 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, and immediate reporting. New hire orientation to include door alarm response skills validation. Followup staff education by 10/4/21 including but not limited to Abuse Policy, Elopement Policy and door alarms, investigation, and reporting to administration and the Indiana State Department of Health per policy.<br><br>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?<br><br>CQI tools were 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 consecutive months. | |

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| | On 8/29/21 at 10:32 a.m., a progress note indicated a call was made to Resident D's family member regarding she was found outside the facility during the previous shift and the staff had "noted" increased confusion with the resident.<br><br>On 8/30/21 at 6:56 a.m., a progress note recorded as a late entry on that date and time, for a date of 8/29/21 at 6:54 a.m., indicated LPN 2 received a call from a staff member reporting Resident D was found outside of the facility in her robe looking for her ride.<br><br>On 8/31/21 at 10:46 a.m., a progress note recorded as a late entry on that date and time, for a date of 8/30/21 at 10:43 a.m., indicated Intervention for elopement: Resident D's door alarm to her patio was turned on to monitor the door 24 hours a day.<br><br>On 9/4/21 at 9:23 p.m., a progress note indicated LPN 2 was passing medications outside of Resident D's apartment around 7:00 p.m., that night, when she opened her door indicating she was headed to breakfast. The resident was reoriented to time of day.<br><br>On 9/8/21 at 3:32 p.m., a progress note indicated Resident D's family member was notified regarding moving | | If threshold of 100% is not met, the<br>results will be reviewed by the IDT team and an action plan will be developed<br>and/or disciplinary action. The Elopement CQI tool will be completed by the<br>Executive Director/designee weekly x 4 weeks, then monthly until compliance is<br>maintained for 6 consecutive months. The<br>CQI tools will be overseen by the Director of Nursing and Executive<br>Director/designee.<br><br>Date<br>the systemic changes will be completed; All systemic changes will be completed<br>by 10/07/2021 | |

her to an interior room without an outside door due to the resident continue to have "some confusion" and the facility wanted to ensure her safety. The family member would call back and let the facility know about the move.

During an interview, on 9/8/21 at 3:08 p.m., Resident D was observed sitting in her recliner in her room. Resident D indicated she left the facility with her walker, but she did not remember the date. She was told by staff members it was around 3:00 a.m. She woke up and wanted to take a walk. She used her patio door to go outside and walk to get fresh air. She ambulated with her walker down the next couple of buildings until she observed "a lady sitting in her car." She knocked on the woman's car window to get her attention, then the woman brought her inside the facility a couple of buildings down from where they were at the woman's car. Resident D indicated she was given "detention" for leaving the building in the middle of the night for a few days. Resident D indicated "detention" was she had to stay in her room and food had to be brought to her room for her to eat and she was not allowed to participate in any of the activities.

During an interview, on 9/8/21 at

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| | 3:22 p.m., QMA 4 indicated he came into work the dayshift on 8/29/21 at 6:00 a.m., to relieve QMA 5. During report with QMA 5, she reported to him Resident D was found outside around 3:00 a.m., that morning with her robe and pajamas on. QMA 4 indicated he was informed by QMA 5 while she was sitting in her car, Resident D knocked on her car window and the resident asked QMA 5 if she was her ride. QMA 4 asked QMA 5 if she had reported this incident to the on-call person and she indicated no. He told her to call and report it immediately because this was an elopement and it had to be reported to the Indiana State Department of Health. He indicated QMA 5 did not realize the incident was considered an elopement or it had to be reported immediately to the on-call person after it happened. He indicated all staff were to carry their pagers, so the door alarm should have been paged out to the staff's pagers. At that time, he demonstrated on a pager he was carrying another resident's door alarm, triggered and was sent to his pager at 1:15 p.m., that day. When he went to check on the resident, she had visitors and her patio door was opened, so she could get fresh air.<br><br>A document, titled "History as of 9/8/21 at 02:56 P [2:56 p.m.] SmartCare," for Resident D | | | |

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| | provided by LPN 3 on 9/8/21 at 3:38 p.m., indicated Resident D's patio alarm sounded on 8/29/21 at 2:59 a.m., and a response was received at 3:01 a.m. (2 minutes later). At that time, the ED indicated it was not determined what staff member responded to the alarm as QMA 5 was outside and there was only a CNA and QMA working on the Assisted Living side. She indicated she investigated the elopement event and tried to get statements from the staff involved from the night shift, but none of them have called back or came into the facility to give or write their statement as to what occurred that night. She and the Interim DON have made several calls to the staff with no "luck."<br><br>A document, titled "Indiana State Department of Health Survey Report System," undated and provided by the ED on 9/8/21 at 3:48 p.m., indicated Resident D was found outside the facility in her robe and pajamas looking for her ride on 8/29/21 at 3:01 a.m. She was taken back into the facility.<br><br>On 9/8/21 at 3:48 p.m., the ED provided a handwritten statement, dated 8/30/21, and indicated it was her handwriting and signature. The statement indicated she was notified Resident D was found outside of the facility at approximately 3:00 | | | |

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| | a.m. QMA 5 had went outside to her car on the right side of the building and observed the resident walking on the sidewalk. Resident D told QMA 5 she was waiting for her ride. The resident was taken back into the facility.<br><br>During an interview, on 9/8/21 at 3:50 p.m., LPN 2 indicated the staff member who found the resident outside was QMA 5. LPN 2 indicated she was not notified of the elopement event until 7:00 a.m. on 8/30/21. She was told by other staff members QMA 5 did not realize this event was an elopement and needed to report it immediately. As soon as she was called about the event, she notified the ED. She was told by QMA 5 this event occurred around 3:00 a.m. She did not get a written statement from her. She asked QMA 5 to leave her written statement of the events, when she found Resident D outside that night, under her door, but QMA 5 did not leave her written statement and she only worked weekends. LPN 2 indicated she did not know anything about the resident going to QMA 5's car and knocking on the window to get her attention. All the staff working that weekend were weekend staff and after several calls by herself and the ED, the staff involved have not come to the facility to give their written statement as to what occurred | | | |

with Resident D leaving her apartment.

Time sheets for the staff members working the night shift from 8/28/21 to 8/29/21, were provided by the ED on 9/8/21 at 4:00 p.m. While reviewing the time sheets and the actual staffing sheets for that night with the ED, she indicated the following staff worked the following units and hours:

LPN 6 worked on the Memory care unit from 10:00 p.m. on 8/28/21 to 2:00 a.m. on 8/29/21 and clocked out at 2:59 a.m. on 8/29/21.

The ED indicated she was not aware CNA 7 worked that shift until she reviewed her time sheet. She indicated after reviewing her time sheet, she worked from 10:00 p.m. on 8/28/21 to 6:00 a.m. on 8/29/21, but she was most likely worked on the memory care Medicaid Waiver side of the facility.

CNA 8 worked on the Memory Care side of the facility from 10:00 p.m. on 8/28/21 to 6:00 a.m. on 8/29/21.

CNA 9 worked the Assisted Living side where Resident D lived from 10:00 p.m. on 8/28/21 to 6:00 a.m. on 8/29/21.

QMA 5 worked on the Assisted Living side of the facility from 2:00 a.m. to 6:00 a.m. on

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| | 8/29/21.<br><br>During an interview, on 9/8/21 at 4:00 p.m., while reviewing the staffing and the time sheets with the ED, she indicated LPN 6 left at 3:00 a.m., that morning (8/29/21), which left a QMA and two CNA's on duty. QMA 5 worked dayshift on 8/28/21 from 6:00 a.m. to 2:00 p.m., then came back into work on 8/29/21 from 2:00 a.m. to 6:00 a.m. QMA 5 did not notify LPN 2 until 7:00 a.m., that morning, then LPN 2 immediately notified the ED. She and LPN 2 have "tried" multiple times to reach the staff involved, but they have had no success.<br><br>After reviewing the interviews, time sheets and Resident D's door alarm documents, indicated while LPN 6 was clocking out at 2:59 a.m. on 8/29/21 and QMA 5 was going out to her car, Resident D eloped out her patio door setting the alarm to her patio door off. The patio door was not answered by a staff member for two minutes, which allowed her to walk around the facility to find QMA 5 sitting in her car. At approximately 3:01 a.m., Resident D knocked on QMA 5's car window to get her attention because she thought she was her ride. The resident was brought back into the facility by QMA 5, who did not report the elopement event to | | | |

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| | administration until 7:00 a.m. on 8/29/21.<br><br>On 9/8/21 at 4:48 p.m., a handwritten statement dated 8/29/21, signed and provided by LPN 2, indicated she received a call at 7:00 a.m. from QMA 5 indicating she found Resident D outside. She asked QMA 5 if this event "just occurred" and QMA 5 indicated "No, it happened around 3 am but I just had time to notify you."<br><br>QMA 5 indicated when asked how the resident was found, that she had went out to her car and saw her outside. When LPN 2 asked QMA 5 if Resident D's door alarm sounded, she was not able to answer that question. QMA 5 indicated the resident was waiting for her ride. QMA 5 was asked to leave a handwritten statement prior to leaving the facility for the end of her shift. At that time, the nurse on duty was called to notify the family and the Physician.<br><br>A current policy, titled "Door Alarms-Residential," dated as revised 12/17 and provided by the ED on 9/8/21 at 3:48 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 | | | |

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| | 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...."<br><br>A current policy, titled "Elopement (Risk and Missing Resident)," dated as revised | | | |

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| | 10/18 and provided by the ED on 9/8/21 at 3:48 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...."<br><br>A current policy, titled "Unusual Occurrences for Residents," dated as revised 12/17 and provided by the ED on 9/8/21 at 3:48 p.m., indicated "...Purposes of Policy: This policy pertains to principles, rules and guidelines formulated and adopted for this community's unusual | | | |

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| | occurrences for residents. Policy: All reportable incidents which occur against a resident will be reported to ISDH...State Rules Related to Incident Reporting State Rules: 410 IAC 16.2-3.1-28(c)--The facility must ensure that all alleged violations involving mistreatment, reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. 410 IAC 16.2-3.1-13 (g)(1)--Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents, including but not limited to, any ...Types of Incidents to be Reported Under Residential Rules (to be reported within 24 hours):...Neglect--failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness...Examples: An action or lack of action that places one or more residents in a life-threatening situation, such as ...c. Staff failing to identify, assess, monitor, and to respond to a resident suffering an acute condition...Elopement of a resident with cognitive deficits who was found outside the facility and whose whereabouts had been unknown or whose | | | |

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| | return involves law enforcement...Definitions: Procedure: Reporting within 24 hours of occurrence: 1. An incident must be reported within 24 hours after discovery of the incident...Report Submission: 1. Online incident Reporting System through the ISDH Gateway: a. All incident report information must be submitted through the online Incident Reporting System...."<br><br>This State finding relates to Complaint IN00361531.<br><br>Based on observation, interview and record review, the facility failed to ensure a resident who was at risk for elopement was free from neglect, when she left her apartment in the middle of the night and wandered around the facility grounds, staff failed to respond to the patio door alarm, and failed to report the event to administration staff and the Indiana Department of Health (IDOH) for 1 of 1 resident being reviewed for neglect during an elopement event. (Resident D)<br><br>Findings include:<br><br>An "Intake Information" document, dated 8/31/21, provided by ISDH (Indiana State Department of Health) on 8/31/21 at 8:32 p.m., indicated an elopement event involving a resident occurred on 8/29/21 at | | | |

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working that weekend were weekend staff and after several calls by herself and the ED, the staff involved have not come to the facility to give their written statement as to what occurred with Resident D leaving her apartment.

Time sheets for the staff members working the night shift from 8/28/21 to 8/29/21, were provided by the ED on 9/8/21 at 4:00 p.m. While reviewing the time sheets and the actual staffing sheets for that night with the ED, she indicated the following staff worked the following units and hours:

LPN 6 worked on the Memory care unit from 10:00 p.m. on 8/28/21 to 2:00 a.m. on 8/29/21 and clocked out at 2:59 a.m. on 8/29/21.

The ED indicated she was not aware CNA 7 worked that shift until she reviewed her time sheet. She indicated after reviewing her time sheet, she worked from 10:00 p.m. on 8/28/21 to 6:00 a.m. on 8/29/21, but she was most likely worked on the memory care Medicaid Waiver side of the facility.

CNA 8 worked on the Memory Care side of the facility from 10:00 p.m. on 8/28/21 to 6:00 a.m. on 8/29/21.

CNA 9 worked the Assisted Living side where Resident D

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| | lived from 10:00 p.m. on 8/28/21 to 6:00 a.m. on 8/29/21.<br><br>QMA 5 worked on the Assisted Living side of the facility from 2:00 a.m. to 6:00 a.m. on 8/29/21.<br><br>During an interview, on 9/8/21 at 4:00 p.m., while reviewing the staffing and the time sheets with the ED, she indicated LPN 6 left at 3:00 a.m., that morning (8/29/21), which left a QMA and two CNA's on duty. QMA 5 worked dayshift on 8/28/21 from 6:00 a.m. to 2:00 p.m., then came back into work on 8/29/21 from 2:00 a.m. to 6:00 a.m. QMA 5 did not notify LPN 2 until 7:00 a.m., that morning, then LPN 2 immediately notified the ED. She and LPN 2 have "tried" multiple times to reach the staff involved, but they have had no success.<br><br>After reviewing the interviews, time sheets and Resident D's door alarm documents, indicated while LPN 6 was clocking out at 2:59 a.m. on 8/29/21 and QMA 5 was going out to her car, Resident D eloped out her patio door setting the alarm to her patio door off. The patio door was not answered by a staff member for two minutes, which allowed her to walk around the facility to find QMA 5 sitting in her car. At approximately 3:01 a.m., Resident D knocked on QMA | | | |

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| | 5's car window to get her attention because she thought she was her ride. The resident was brought back into the facility by QMA 5, who did not report the elopement event to administration until 7:00 a.m. on 8/29/21.<br><br>On 9/8/21 at 4:48 p.m., a handwritten statement dated 8/29/21, signed and provided by LPN 2, indicated she received a call at 7:00 a.m. from QMA 5 indicating she found Resident D outside. She asked QMA 5 if this event "just occurred" and QMA 5 indicated "No, it happened around 3 am but I just had time to notify you."<br><br>QMA 5 indicated when asked how the resident was found, that she had went out to her car and saw her outside. When LPN 2 asked QMA 5 if Resident D's door alarm sounded, she was not able to answer that question. QMA 5 indicated the resident was waiting for her ride. QMA 5 was asked to leave a handwritten statement prior to leaving the facility for the end of her shift. At that time, the nurse on duty was called to notify the family and the Physician.<br><br>A current policy, titled "Door Alarms-Residential," dated as revised 12/17 and provided by the ED on 9/8/21 at 3:48 p.m., indicated "Title: Door Alarms--Residential Care | | | |

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| | 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 | | | |

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| | Missing Resident/Resident Elopement Policy...."<br><br>A current policy, titled "Elopement (Risk and Missing Resident)," dated as revised 10/18 and provided by the ED on 9/8/21 at 3:48 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...."<br><br>A current policy, titled "Unusual Occurrences for Residents," dated as revised 12/17 and provided by the ED on 9/8/21 at | | | |

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| | 3:48 p.m., indicated "...Purposes of Policy: This policy pertains to principles, rules and guidelines formulated and adopted for this community's unusual occurrences for residents. Policy: All reportable incidents which occur against a resident will be reported to ISDH...State Rules Related to Incident Reporting State Rules: 410 IAC 16.2-3.1-28(c)--The facility must ensure that all alleged violations involving mistreatment, reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. 410 IAC 16.2-3.1-13 (g)(1)--Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents, including but not limited to, any ...Types of Incidents to be Reported Under Residential Rules (to be reported within 24 hours):...Neglect--failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness...Examples: An action or lack of action that places one or more residents in a life-threatening situation, such as ...c. Staff failing to identify, assess, monitor, and to respond | | | |

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| | to a resident suffering an acute condition...Elopement of a resident with cognitive deficits who was found outside the facility and whose whereabouts had been unknown or whose return involves law enforcement...Definitions: Procedure: Reporting within 24 hours of occurrence: 1. An incident must be reported within 24 hours after discovery of the incident...Report Submission: 1. Online incident Reporting System through the ISDH Gateway: a. All incident report information must be submitted through the online Incident Reporting System...."<br><br>This State finding relates to Complaint IN00361531. | | | |
| R 0086 | Administration and Management - Deficiency<br><br>410 IAC 16.2-5-1.3(a)(1-2)<br><br>The licensee:<br><br>(1) is responsible for compliance with all applicable laws; and<br><br>(2) has full authority and responsibility for the:<br><br>(A) organization;<br><br>(B) management;<br><br>(C) operation; and<br><br>(D) control; | R 0086 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D completed treatment for urinary tract infection. Resident D's patio door alarm tested for proper function and alarmed 24 hours/day. Safety knob placed on Resident D's patio door to aide recall not to go out patio door. Service plan reviewed and increased to include escorts to and from meals 9/21/21. Resident B moved to apartment without patio door until alternate placement found. Resident C continued to reside on memory | 10/05/2021 |

of the licensed facility.

The delegation of any authority by the licensee does not diminish the responsibilities of the licensee.

Based on interview and record review, the facility failed to ensure safe daily operations of the facility were in place to ensure residents safety from previous and current elopement events from the facility for 3 of 3 residents reviewed for their safety. (Residents B, C and D)

Findings include:

An ISDH Survey Report (2567), dated August 30, 2021, indicated the facility had previous elopements on 8/16/21, 8/19/21 and 8/25/21 for Residents B and C.

An "Intake Information" document, dated 8/31/21, provided by ISDH (Indiana State Department of Health) on 8/31/21 at 8:32 p.m., indicated an elopement event involving a resident occurred on 8/29/21 at 3:01 a.m. The event was reported to the ISDH gateway (reporting system for unusual occurrences) on 8/30/21 at 8:47 p.m.

During an interview, on 9/8/21 at 2:35 p.m., with the ED (Executive Director), LPN 2 and LPN 3 in attendance, LPN 2 indicated Resident D ambulated out the patio door of her

care unit. Executive Director employed at time of said incidents was relieved of duties on 9/16/21.

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. Staff re-educated by 9/13/21, including QMA 5, 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.Followup staff education by 10/4/21 by Interim Executive
Director/designee including but not limited to Abuse Policy, Elopement Policy and door alarms, investigation, and reporting of Unusual Occurrences to administration and the Indiana State Department of Health per policy.
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, including QMA 5, 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

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| | apartment. QMA 5 went out to her car at approximately 3:00 a.m. on 8/29/21, and she noticed Resident D ambulating on the sidewalk in front of the facility (which faced the west side of the building) dressed in her robe and pajamas. She indicated Resident D's apartment faced the North side of the building. She was outside for an undetermined amount of time. LPN 2 indicated Resident D told QMA 5 she was waiting for a ride. The resident was confused off and on and her current BIMS (Brief Interview Mental Status) was 12 out of 15 (indicated she had a mild cognitive impairment). The ED indicated every resident's patio door was alarmed from 8:00 p.m., until 7:00 a.m., as a safety measure. When asked who responded to the alarm from Resident D's patio door, the ED indicated she was not sure anyone responded to the sounding patio door alarm.<br><br>Resident D's record was reviewed at 4:00 p.m. Diagnoses included, but were not limited to, asthma, edema in legs, osteopenia, and coronary artery disease.<br><br>On 8/29/21 at 10:32 a.m., a progress note indicated a call was made to Resident D's family member regarding she was found outside the facility during the previous shift and the | | orientation to include door alarm response skills validation.Followup staff education by 10/4/21 by Interim Executive Director/designee including but not limited to Abuse Policy, Elopement Policy and door alarms, investigation, and reporting of Unusual Occurrences to administration and the Indiana State Department of Health per policy.<br><br>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?<br><br>CQI tool will be initiated by 10/02/21 as monitoring tool. The Elopement 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.<br><br>Date the systemic changes will be completed; All systemic changes will be completed by 10/05/2021 | |

staff had "noted" increased confusion with the resident.

On 8/30/21 at 6:56 a.m., a progress note recorded as a late entry on that date and time, for a date of 8/29/21 at 6:54 a.m., indicated LPN 2 received a call from a staff member reporting Resident D was found outside of the facility in her robe looking for her ride.

During an interview, on 9/8/21 at 3:22 p.m., QMA 4 indicated he came into work the dayshift on 8/29/21 at 6:00 a.m., to relieve QMA 5. During report with QMA 5, she reported to him Resident D was found outside around 3:00 a.m., that morning with her robe and pajamas on. QMA 4 indicated he was informed by QMA 5 while she was sitting in her car, Resident D knocked on her car window and the resident asked QMA 5 if she was her ride. QMA 4 asked QMA 5 if she had reported this incident to the on-call person and she indicated no. He told her to call and report it immediately because this was an elopement and it had to be reported to the Indiana State Department of Health. He indicated QMA 5 did not realize the incident was considered an elopement or it had to be reported immediately to the on-call person after it happened.

A document, titled "History as of 9/8/21 at 02:56 P [2:56 p.m.]

SmartCare," for Resident D provided by LPN 3 on 9/8/21 at 3:38 p.m., indicated Resident D's patio alarm sounded on 8/29/21 at 2:59 a.m., and a response was received at 3:01 a.m. (2 minutes later). At that time, the ED indicated it was not determined what staff member responded to the alarm as QMA 5 was outside and there was only a CNA and QMA working on the Assisted Living side. She indicated she investigated the elopement event and tried to get statements from the staff involved from the night shift, but none of them have called back or came into the facility to give or write their statement as to what occurred that night. She and the Interim DON have made several calls to the staff with no "luck."

During an interview, on 9/8/21 at 3:50 p.m., LPN 2 indicated the staff member who found the resident outside was QMA 5. LPN 2 indicated she was not notified of the elopement event until 7:00 a.m. on 8/30/21. She was told by other staff members QMA 5 did not realize this event was an elopement and needed to report it immediately. As soon as she was called about the event, she notified the ED. She was told by QMA 5 this event occurred around 3:00 a.m. She did not get a written statement from her. She asked QMA 5 to leave her written statement of

the events, when she found Resident D outside that night, under her door, but QMA 5 did not leave her written statement and she only worked weekends. LPN 2 indicated she did not know anything about the resident going to QMA 5's car and knocking on the window to get her attention. All the staff working that weekend were weekend staff and after several calls by herself and the ED, the staff involved have not come to the facility to give their written statement as to what occurred with Resident D leaving her apartment.

During an interview, on 9/8/21 at 4:00 p.m., while reviewing the staffing and the time sheets with the ED, she indicated LPN 6 left at 3:00 a.m., that morning (8/29/21), which left a QMA and two CNA's on duty. QMA 5 worked dayshift on 8/28/21 from 6:00 a.m. to 2:00 p.m., then came back into work on 8/29/21 from 2:00 a.m. to 6:00 a.m. QMA 5 did not notify LPN 2 until 7:00 a.m., that morning, then LPN 2 immediately notified the ED. She and LPN 2 have "tried" multiple times to reach the staff involved, but they have had no success.

After reviewing the interviews, time sheets and Resident D's door alarm documents, indicated while LPN 6 was clocking out at 2:59 a.m. on

8/29/21 and QMA 5 was going out to her car, Resident D eloped out her patio door setting the alarm to her patio door off. The patio door was not answered by a staff member for two minutes, which allowed her to walk around the facility to find QMA 5 sitting in her car. At approximately 3:01 a.m., Resident D knocked on QMA 5's car window to get her attention because she thought she was her ride. The resident was brought back into the facility by QMA 5, who did not report the elopement event to administration until 7:00 a.m. on 8/29/21.

A current policy, titled "Door Alarms-Residential," dated as revised 12/17 and provided by the ED on 9/8/21 at 3:48 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...."

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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...."

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This State finding relates to Complaint IN00361531.

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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 |
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