STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155779	A. BUILDING 00 B. WING	12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BLVD EAST NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: December 11, 12, 13, 14, 15, and 18, 2023 Facility number: 012305 Provider number: 155779 AIM number: 200987990 Census Bed Type: SNF/NF: 26 SNF: 32 Total: 58 Census Payor Type: Medicare: 18 Medicaid: 26 Other: 14 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 21, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by Prairie Lakes Health Center that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Prairie Lakes The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. **Corrections to be completed by 1/8/23**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebeccah Garza	RN Clinical Support	12/30/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to follow a physician's order for fluid restriction for 1 of 1 residents reviewed for edema (Resident 5), and failed to follow a physician's order for insulin administration parameters for 1 of 1 residents reviewed for insulin administration. (Resident 36) Findings include: 1. The clinical record for Resident 5 was reviewed on 12/13/23 at 9:56 a.m. Diagnoses included congestive heart failure and chronic obstructive pulmonary disease. Current physician orders included to encourage 1800 ml (milliliters) per day of fluid restriction, dated 9/3/23. A Resident Profile indicated a fluid restriction and to ask the nurse before providing any fluids. Review of the Intake Totals documentation, for November and December of 2023, indicated the resident received greater than 1800 ml of fluids on 11/16/23 (1830 ml, 11/19/23 (2880 ml), 12/1/23 (1920 ml), 12/3/23 (1920 ml), 12/4/23 (1920 ml), 12/8/23 (2240 ml), and 12/14/23 (2880 ml). During an interview on 12/14/23 at 11:19 a.m., CNA 7 indicated she was aware of Resident 5's fluid restriction, but was unsure of the amount. She documented meal fluid intakes and if water was provided to her outside of meals. She had not informed the nurse when providing additional fluids. During an interview on 12/15/23 at 10:26 a.m., the	F 0684	**F684 Quality of Care** **1) Immediate actions taken for those residents identified:** No residents were affected. No adverse effects noted. Resident 5 and Resident 36 were reviewed to ensure that all Vital Signs out of Physician Ordered Parameters and Physician was made aware and documentation was completed if indicated. **2) How the facility identified other residents:** All Residents in house receiving medications that require a parameter for vital signs were reviewed and ensured proper documentation was in place and Physician was made aware DHS/Designee. **3) Measures put into place/ System changes:** All Nurses were educated by DHS/Designee on Fluid Restriction Guidelines and Change of Condition/ Physician Notification Guidelines As a measure of ongoing compliance, the DHS/designee will complete a Fluid Restriction and Change of Condition QAPI Audit.	01/08/2024

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	DON indicated Resident 5 had been educated regarding the importance of her fluid restriction. The education had not been documented. The fluid intake documentation under the point of care section in the electronic health record was the total intake for the day. A Self Determination of Care or Informed Refusal and Non-Compliance observation was not completed for the resident. During an interview on 12/15/23 at 10:47 a.m., Resident 5 indicated she was aware of a fluid restriction, but was unsure about the amount. She was unaware of ever going over her allotted intake amount. The staff brought her water if she requested it outside of meal times and when they passed fluids. A current facility policy, revised 12/1/21, titled "Guidelines for Fluid Restriction," provided by the Administrator on 12/14/23 at 12:35 p.m., indicated to ensure fluids are provided within the physician order guidelines. Procedures...6. Fluid consumption shall be reviewed by shift to determine adjustments necessary in the fluid intake of the resident on the restriction in order to meet their established fluids needs. 7. The resident and/or responsible party should be educated regarding the reason and importance of fluid restriction. 8. Should the resident and/or responsible party chose not to comply with the recommended fluid restriction a Self Determination of Care or Informed Refusal and Non-Compliance observation should be completed explaining the risk(s) of noncompliance. 2. The clinical record for Resident 36 was reviewed on 12/12/23 at 2:22 p.m. Diagnoses included diabetes mellitus type II and diabetic neuropathy. Physician orders included Humulin (insulin to		**4) How the corrective actions will be monitored:** As a measure of ongoing compliance, the DHS/Designee, will complete audits of 5 resident to ensure that all Vital Signs Parameters are being followed and Physician Notification has been completed 2x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	treat diabetes mellitus) R Kwikpen, 220 units twice a day. Special instructions: hold if blood sugar is less than 200 mg/dL and call if greater than 300 mg/dL. The order was dated 11/17/23 and was discontinued on 11/28/23. A review of the electronic medication administration record (eMAR) for 11/17/23 through 11/28/23, indicated the resident's blood sugar was above 300 mg/dL (milligram per deciliter) on 11/19/23 (426 mg/dl), 11/20/23 (329 mg/dl), 11/22/23 (372 mg/dl), 11/23/23 (441 mg/dl), 11/24/23 (365 mg/dl), 11/25/23 (435 mg/dl), and 11/26/23 (447 mg/dl), when checked for the evening dose. The clinical record lacked documentation of physician notification. A current physician's order, dated 11/28/23, indicated Humulin R Kwikpen, 110 units twice a day. Special instructions: hold if blood sugar is less than 200 mg/dL and call if greater than 300 mg/dL. A review of the eMAR for 11/28/23 through 12/12/23, indicated the resident's blood sugar was above 300 mg/dL on 11/28/23, 11/29/23, 12/1/23 (480 mg/dl), 12/2/23 (415 mg/dl), 12/4/23 (427 mg/dl), 12/7/23 (307 mg/dl), 12/9/23 (406 mg/dl), and 12/11/23 (301 mg/dl) when checked for the evening dose. The clinical record lacked documentation of physician notification. During an interview on 12/13/23 at 11:10 a.m., the DON indicated the physician had wanted to monitor blood sugars over 300 mg/dL and felt he had been notified, but the staff had not documented the notifications. A current facility policy, reviewed 12/31/22, titled, "Physician-Provider Notification Guidelines,"			

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	provided by the DON on 12/14/23 at 1:21 p.m., included: "Procedures...11. Attempts to notify the physician/provider and their response should be documented in the resident electronic health record." 3.1-37(a)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and			

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	§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure narcotics were reconciled per facility policy for 4 of 4 medication carts reviewed for medication storage. (Noble Lane, Conner, Pioneer front, and Pioneer back carts) Findings include: 1. During a medication storage observation of the Pioneer back cart, accompanied by RN 6 on 12/15/23 at 10:01 a.m., the "Narcotic Count Sheet" record was reviewed and the following dates and times/shifts lacked reconciliation of controlled medications: In November 2023- 11/15: 12:00 p.m. - 10:00 p.m. 11/16: 2:00 p.m. - 6:00 p.m. 11/17: 6:00 p.m. - 10:00 p.m. 11/22: 2:00 p.m.- 10:00 p.m. 11/24: 1:00 a.m. - 5:00 a.m. 11/25: 8:00 p.m. - 10:00 p.m. 11/26: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. 11/29: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m. 11/30: 8:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. In December 2023- 12/1: 6:00 a.m. - 2:00 p.m. and 8:00 p.m. - 10 p.m. 12/2: 9:00 p.m. - 10:00 p.m. 12/3: 8:00 p.m. -10:00 p.m. and 10:00 p.m. - 6:00 a.m.	F 0755	**F755 Pharmacy Services/Procedures/Pharmacist/Records** **1) Immediate actions taken for those residents identified:** No residents were affected. No adverse effects noted. All Residents receiving narcotics were reviewed to ensure that all documentation was completed for Narcotic Count every shift. **2) How the facility identified other residents:** All Residents in house receiving medications that receive narcotics have been reviewed by DHS/Designee. **3) Measures put into place/ System changes:** All Nurses and Qualified Medication Assistant we educated by DHS/Designee on Medication Storage Policy regarding Narcotic Medication Storage. As a measure of ongoing compliance, the DHS/designee will complete a Narcotic Log Storage QAPI Audit. **4) How the corrective actions**	01/08/2024

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	12/8: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m. 12/9: 4:30 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. 12/13: 2:00 p.m.- 4:00 p.m. and 2:00 a.m.- 6:00 a.m. 12/14: 2:00 p.m.- 10:00 p.m. 2. During a medication storage observation of the Pioneer front cart, accompanied by RN 6 on 12/15/23 at 10:01 a.m., the "Narcotic Count Sheet" record was reviewed and the following dates and times/shifts lacked reconciliation of controlled medications: In November 2023- 11/4: 10:00 p.m. - 2:00 a.m. 11/5: 6:00 p.m.- 10:00 p.m. 11/7: 2:00 p.m. - 6:00 p.m. 11/8: 2:30 p.m. - 7:00 p.m. 11/9: 2:30 p.m. - 6:00 p.m. 11/10: 12:00 p.m. - 3:00 p.m. 11/14: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. 11/27: 10:00 p.m. - 6:00 a.m. 11/29: 7:00 p.m. - 10:00 p.m. In December 2023- 12/1: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m. 12/3: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. 12/5: 10:00 p.m. - 6:00 a.m. 12/6: 11:00 p.m. - 6:00 a.m. 12/7: 7:00 p.m. - 10:00 p.m. 12/8: 7:00 p.m. - 10:00 p.m. 12/10: 2:00 p.m. - 5:00 p.m. and 10:00 p.m. - 6:00 a.m. 12/12: 2:00 a.m. - 6:00 a.m.		**will be monitored:** As a measure of ongoing compliance, the DHS/Designee, will complete audits of 2 medication carts to ensure that all Narcotic Logs are completed with no missing documentation 2x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	12/13: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 2:00 a.m. - 6:00 a.m. 12/14: 2:00 p.m.- 6:00 p.m. and 2:00 a.m. - 6:00 a.m. 3. During a medication storage observation of the Noble hall cart, accompanied by RN 8 on 12/15/23 at 10:15 a.m., the "Narcotic Count Sheet" record was reviewed and the following dates and times/shifts lacked reconciliation of controlled medications: In November 2023- 11/23: 6:00 a.m. - 8:00 a.m. 11/29: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. In December 2023- 12/1: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 6:00 p.m. 12/14: 6:00 p.m. - 7:00 p.m. 4. During a medication storage observation of the Conner cart, accompanied by RN 6 on 12/15/23 at 10:01 a.m., the "Narcotic Count Sheet" record was reviewed and the following dates and times/shifts lacked reconciliation of controlled medications: In November 2023- 11/7: 4:00 p.m. - 6:00 p.m. 11/9: 10:00 p.m. - 6:00 a.m. 11/12: 6:00 a.m. - 2:00 p.m. 11/14: 9:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. 11/17: 6:00 p.m. - 10:00 p.m. 11/21: 6:00 p.m. - 8:00 p.m. 11/22: 7:00 p.m. - 8:00 p.m. 11/23: 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 11:00			

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	p.m. 11/27: 6:00 p.m. - 10:00 p.m. In December 2023- 12/3: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. 12/4: 8:00 p.m. - 10:00 p.m. 12/5: 8:00 p.m.- 10:00 p.m. 12/6: 6:00 p.m. - 10:00 p.m. 12/7: 6:00 p.m. - 10:00 p.m. 12/8: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. 12/10: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 12:00 a.m. 12/11: 10:00 p.m. - 11:00 p.m. 12/12: 10:00 p.m. - 6:00 a.m. 12/13: 4:00 p.m. - 6:00 p.m. During an interview on 12/15/23 at 3:05 p.m., the Director of Nursing indicated the expectation for staff was the narcotic count book to be signed at the beginning of each shift. Review of a current facility policy, revised 1/17, titled "Medication Storage in the Facility," provided by the Administrator on 12/18/23 at 9:59 a.m., indicated the following: "...E. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two staff members as acceptable to location regulations and is documented...." 3.1-25(b)(3)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review.			

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	§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent			

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	action to protect the resident. Based on record review and interview, the facility failed to ensure pharmacy recommendations were reviewed by the physician and collaboratively acted upon for 2 of 5 residents reviewed for unnecessary medications. (Resident 15 and Resident 2) Finding includes: 1. Resident 15's clinical record was review on 12/14/23 at 3:03 p.m. Current diagnoses include, vascular dementia, bipolar disorder, and personality disorder. The residents current physician's orders included the following psychotropic medications: Depakote 250 mg (an antiseizure medication used as a mood stabilizer)- one tablet two times daily, ordered on 7/17/22. Latuda 40 mg (an antipsychotic medication)- one tablet one time daily, ordered on 7/3/22. Sertraline 25 mg (an antidepressant medication)- one tablet one time daily, ordered 1/28/23. A July 31, 2023 pharmacy recommendation indicated the resident was receiving sertraline, Latuda, and depakote, which were due for gradual dosage reduction (GDR) evaluation. If GDR was clinically contraindicated, documention that risk vs. benefits had been considered was to be completed. A September 6, 2023 pharmacy recommendation indicated the resident was receiving sertraline, Latuda, and depakote, which were due for gradual dosage reduction (GDR) evaluation. If GDR was clinically contraindicated, documention that risk vs. benefits had been considered was to be completed.	F 0756	**F756 Drug Regimen Review, Report Irregular** **1) Immediate actions taken for those residents identified:** No residents were affected. No adverse effects noted. Resident 2 and Resident 15 medications were assessed and reviewed with the physician and ensured that if gradual dose reduction were contraindicated that the physician reviewed and document the contraindication and reason for declining the gradual dose reduction. **2) How the facility identified other residents:** All Residents in house receiving medications that require a gradual dose reduction were reviewed and ensured proper documentation to support continued use as indicated was in place for all recommendations declined from the physician by DHS/Designee. **3) Measures put into place/ System changes:** Medical Director/ Nurse Practioner/Social Service Director/ Nurse Managers educated by DHS/Designee on Psychotropic Medication Usage and Gradual Dose Reduction. As a measure of	01/08/2024

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	155779	A. BUILDING 00 B. WING	12/18/2023

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	An October 1, 2023 pharmacy recommendation indicated the resident was receiving sertraline, Latuda, and depakote, which were due for gradual dosage reduction (GDR) evaluation. If GDR was clinically contraindicated, documention that risk vs. benefits had been considered was to be completed. A November 1, 2023 pharmacy recommendation indicated the resident was receiving sertraline, Latuda, and depakote, which were due for gradual dosage reduction (GDR) evaluation. If GDR was clinically contraindicated, documention that risk vs. benefits had been considered was to be completed. The recommendation had been declined without rationale per progress note discussed in a GDR meeting. The clinical record lacked responses to any of the above pharmacy recommendations. During an interview on 12/15/23 at 10:59 a.m., the DON indicated the facility had talked about GDRs in the behavior and psychoactive medication meetings. She was not aware how the pharmacy recommendations were communicated with the Psychiatric Nurse Practitioner (NP) and she did not know if the NP made written statements of contraindications. During an interview on 12/18/23 at 10:00 a.m., the DON indicated she did not have any written responses to the pharmacy recommendations for Resident 15.2. Resident 2's clinical record was reviewed on 12/12/23 at 3:26 p.m. Diagnoses included dementia and anxiety disorder. A pharmacy recommendation, dated 5/4/23, indicated quetiapine (an antipsychotic		ongoing compliance, the DHS/designee, will complete a Psychoactive Medication QAPI Audit. **4) How the corrective actions will be monitored:** As a measure of ongoing compliance, the DHS/Designee, will complete audits of 5 resident to ensure that Gradual Dose Reduction Reviews are completed including but not limited to proper documentation if Recommendation is declined 2x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	medication) 25 mg (milligram), two times daily, lacked an allowable diagnosis to support its use. The recommendation was to add an appropriate diagnosis, or consider a reduction to being tapering off the medication. The electronic health record (EHR) lacked indication of physician review. A follow-up recommendation, dated 6/1/23, indicated the outcome as "pending," with no indication of physician review in the EHR. A pharmacy recommendation, dated 9/11/23, indicated the resident had an order for bupropion immediate release (to treat anxiety) 150 mg daily. The immediate release formulation was recommended to be administered two to three times daily, whereas the XL (extended release) was a once daily dosing. The recommendation was to change the order to the XL 150 mg daily. A follow-up recommendation, dated 10/10/23, indicated the outcome as "declined without rationale," with no documentation of a physician review in the EHR. During an interview on 12/18/23 at 2:20 p.m., the DON indicated she was unaware of any documentation regarding specific contraindication statements or physician signed recommendation forms. The interdisciplinary team (IDT) reviewed the recommendations in monthly meetings, but she was unaware of any documentation regarding the recommendations. During a telephone interview on 12/18/23 at 2:43 p.m., the IDT Social Services Director indicated she was unaware of any specific documentation regarding contraindication statements or specific documented reason for declining recommendations. There was no physician or nurse practitioner signed pharmacy recommendations.			

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	During an interview on 12/18/23 at 3:13 p.m., the Corporate Nurse Consultant indicated the facility had no specific policy regarding pharmacy recommendations and followed the CMS (Centers for Medicare and Medicaid) regulatory guidelines. 3.1-25(i)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: December 11, 12, 13, 14, 15, and 18, 2023 Facility number: 012305 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 21, 2023.	R 0000	The submission of this plan of correction does not indicate an admission by Prairie Lakes Health Center that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Prairie Lakes The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. **Corrections to be completed by 1/8/23**	
R 0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense			

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Bldg. 00	(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 provide supervision for a newly admitted resident with a history of elopement attempts from exiting a secured dementia care unit for 1 of 1 residential records reviewed for elopement (Resident 56). This deficient practice resulted in the resident being unsupervised outside the facility for up to one hour and traveling approximately 360 yards from the facility to a major thoroughfare, where a neighbor contacted the local police. Findings include: Resident 56's clinical record was reviewed on 12/18/23 at 9:30 a.m. Diagnosis included dementia, anxiety and depression. The resident had a 12/15/23 admission order to reside on a "Secured/Locked Unit." A 12/15/23 at 12:59 p.m., "AL/Legacy Eval and Service Plan" indicated the following: Elopement Risk Review...Indicate if the resident is an elopement list. The answer "no" was selected. The document included the following options for evaluation of elopement risk: History of exit seeking, Voices statements of leaving, Exhibits periods of pacing, agitation or wandering towards an exit, Resident has a history of elopement, and Elopement Service Plan. The list was marked as not applicable.	R 0052	**R052 Resident Rights** **1) Immediate actions taken for those residents identified:** No residents were affected. No adverse effects noted. Resident 56 was reviewed to ensure all assessments were completed and were an accurate reflection of Resident with interventions in place for Resident Care needs was completed. **2) How the facility identified other residents:** All Residents with exit seeking behaviors were reviewed by DHS/Designee. **3) Measures put into place/ System changes:** All Staff were educated by DHS/Designee on Guidelines for Elopement. As a measure of ongoing compliance, the DHS/designee will complete an Elopment QAPI Audit. **4) How the corrective actions**	01/08/2024

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	A 12/15/23 at 1:05 p.m., admission Nursing Progress Note indicated the resident was being admitted from another facility after staying there for just five days due to exit seeking. The resident was admitted to the Prairie Lakes' "locked unit". The resident had a history of exit seeking and would be monitored closely. The clinical record lacked a formal plan for the "daily close monitoring" of the resident. A 12/16/23 at 10:30 a.m. Nursing Progress Note indicated the facility staff noticed the resident was not present in the main dining room and began looking for the resident. The Director of Environmental Services found the resident outside and was waiting for the police to identify the resident because a pedestrian had called the police when they found them. The employee identified the resident and police escorted them back to the dementia unit. An undated facility document titled, "Elopement Investigation" indicated the resident was last seen at 9:30 a.m. sitting on the couch in the TV room. No alarms were sounding to alert staff Resident 56 had left the unit, who had exited the patio door to the secured patio. The resident had exited the campus for less than 60 minutes when staff started searching for them. At 10:45 a.m., the Environmental Services Director saw the resident sitting in a police car on Cumberland Street. A 12/16/23, "Statement of Witness Form" completed by the Environmental Services Director indicated the following they received a phone call around 10:45 a.m. about a missing resident from the dementia unit. During the perimeter search, they observed the resident standing by Cumberland Road with a women and child who		**will be monitored:** As a measure of ongoing compliance, the DHS/Designee, will complete audits of 6 resident to ensure that all Elopement Risk Assessments are completed timely and accurate and exiting seeking interventions are in place and effect weekly x4 weeks, then Bimonthly x 4 weeks, then monthly x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	

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	were helping the resident. The police pulled up and walked up to the resident and asked his name. The officer was informed and directed to the dementia unit with the front door code so he could assist the resident back to the unit. During an interview on 12/18/23 at 11:00 a.m., the Dementia Unit Director indicated the door to the patio had an alarm and the alarm would sound when the door is open unless an individual entered the override code. The gate in the courtyard also required a code to exit. During an observation on 12/18/23 at 11:02 a.m., the patio exit door was noted to have a key pad alarm system. The courtyard, which could be entered from the patio door, had a fence enclosing the side that was not enclosed by facility walls. The fence and gate were 5 feet or greater in height. There was an code style lock on the gate. During an interview on 12/18/23 at 11:14 a.m., Resident 56's spouse indicated the resident had a history of elopement at home, which was the reason the family had sought placement in a secured dementia unit. The resident had resided in another facility prior to coming to this facility and had displayed exiting-seeking at the previous facility and had tried to open a window(s) to exit. During an observation on 12/18/23 at 11:20 a.m., the distance from the locked "Legacy" dementia unit to Cumberland Road, where the resident was located, was approximately 3 football fields or 360 yards, slightly less than 1/4 mile, from the secured unit. Because there are both roads and lawns separating the unit and Cumberland Road the distance could not be driven for actual distance and a visual observation was completed. Cumberland Road was a four-lane thoroughfare			

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	with cars traveling at speeds of 30 miles per hour or greater. Some areas on Cumberland road were five lanes wide to accommodate a turning lane. There were areas on Cumberland Road without a shoulder wider than one foot. A significant amount of traffic was traveling on the road. During an interview on 12/18/23 at 11:39 a.m., the Administrator indicated she had watched a video of Resident 56 exiting through the patio door. The staff indicated the door alarm did not sound. In good weather, an override code could be entered to allow resident free access to the courtyard. Because the temperature was nice that day, a resident who frequently goes outside for fresh air had gone out to the courtyard. The staff did not remember who set the override code to allow free access to the courtyard. The courtyard gate does have a key pad lock with code. When checked on the day of elopement, the courtyard gate was found to be unlocked. The Administrator then locked the gate. The Administrator indicated the resident's spouse stated the resident was very mechanical and could have tinkered with the lock in someway. The lock company did an inspection, however the facility has yet to receive a report. To the Administrator's understanding, the gait lock could have been manipulated in someway because something with the wiring appeared incorrect when the company inspected it. The company ensured all parts of the lock were currently functioning properly. The facility did not have an answer to the courtyard gate being unlocked. During an interview on 12/18/23 at 11:43 a.m., the DON indicated the resident's admission care plan indicating the resident was not an elopement risk was simply human error. The resident was residing in a secured dementia unit because of the			

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	risk of elopement. A current, 12/31/22, facility policy titled, "Guideline for Elopement/Missing Resident", provided by the Administrator on 12/18/23 at 10:00 a.m., indicated the following: "...Purpose to establish guidelines to report and investigate all reports of elopement/missing persons. It is the responsibility of all personnel to report any residents attempting to leave the premises or suspected of being missing..." A current, 8/29/19, facility policy titled, "Abuse and Neglect Procedural Guidelines, provided by the Administrator on 12/11/23 following the entrance conference, indicated the following: ..."NEGLECT-is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress...."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may			

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	request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were signed by resident or resident representatives for 3 of 7 reviewed for service plans. (Residents 19, 30, and 101) Findings include: 1. Resident 19's clinical record was reviewed on 12/18/23 at 12:02 p.m. Diagnosis included coronary artery disease and hypothyroidism. A current service plan, dated 8/8/23, lacked a resident or resident representative signature. 2. Resident 30's clinical record was reviewed on 12/18/23 at 9:12 a.m. Diagnosis included late onset Alzheimer's disease, congestive heart failure, and osteoarthritis A current service plan, dated 10/24/23, lacked a resident or resident representative signature. 3. Resident 101's closed clinical record was reviewed on 12/18/23 at 10:07 a.m. Diagnosis included Parkinson's disease, atrial fibrillation, and	R 0217	**R217 Evaluation** **1) Immediate actions taken for those residents identified:** No residents were affected. No adverse effects noted. Resident 19, Resident 30 and Resident 101 were reviewed to ensure Resident Service Plan had been completed and signature in place from Resident or POA. **2) How the facility identified other residents:** All Residents Assisted Living Service Plans were reviewed by DHS/Designee. **3) Measures put into place/ System changes:** All Nurses/Nurse Managers/Memory Care Directors were educated by DHS/Designee	01/08/2024

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	hypertension. An admission service plan, dated 10/18/23, lacked a resident or resident representative signature. During an interview, on 12/18/23 at 2:00 p.m., the Director of Nursing indicated she was not able to find signed service plans for residents 19, 30, and 101. A current facility policy, reviewed on 3/24/23, titled "AL-Evaluation and Service Plan Guidelines", provided by the Administrator on 12/18/23 at 2:19 p.m., indicated the following: "... 2. A service plan shall be identified and implemented in response to the resident's evaluation and in the collaboration with the resident and/or responsible party."		on Service Plan Guidelines. As a measure of ongoing compliance, the DHS/designee will complete a Service Plan QAPI Audit. **4) How the corrective actions will be monitored:** As a measure of ongoing compliance, the DHS/Designee, will complete audits of 5 resident to ensure that Service Plan Reviews are completed including signatures completed weekly x4 weeks, then Bimonthly x 4 weeks, then monthly x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.	