STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/03/2023

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

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00400382. Complaint IN00400382 - Substantiated. State deficiencies related to the allegations are cited at R0052. Survey date: February 03, 2023 Facility number: 010416 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 10, 2023.	R 0000	The following is the Plan of Correction for Brookdale Granger regarding the Statement of Deficiencies dated February 3, 2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. A plan of correction (POC) must be submitted for these state findings. The POC must contain the following: · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident admitted to geri psych hospital on 1.30.23 for medication	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Woodcox	Executive Director	02/24/2023

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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			review. Resident readmitted to community with one on one sitter on 2.14.23. Resident will continue to have one on one care until exit seeking behaviors are resolved. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All ambulatory residents have the potential to be affected by alleged deficient practice. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Community will install wooden window stops in addition to manufacturer installed window stops to every exterior window in the community. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Maintenance Director or designee will complete monthly inspections to windows and window stops. Inspections will be documented in work order system. · By what date the systemic changes will be completed. Window stops to be installed no later than March 6, 2023.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from:			

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	(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 eloped through a first-floor window, without staff knowledge, and wandered away from the facility property. The resident was found 1.6 miles from the facility and her location was unknown for approximately three (3) hours. (Resident B) Finding Includes: During a walkthrough of the facility, on 02/03/23 at 9:51 a.m., Resident B's room was found on the second floor of the facility. Resident B was not available for observation. The record for Resident B was reviewed on 02/03/2023 at 10:23 a.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, bandemia (too many white blood cells being released by bone marrow into the bloodstream) and confusion arousals (when a sleeping person appears to wake up, but their behavior was unusual or strange). Resident B admitted to the facility on 01/16/23. A nurses' note, dated 01/17/2023 at 2:47 p.m., indicated "...Alert Charting Note...Resident continues on f/u (follow up) new admit. Up ad lib (as much and as often as wanted) per self, resident busy finding things to do throughout the shift. Complained of being bored and wanting to	R 0052	A plan of correction (POC) must be submitted for these state findings. The POC must contain the following: · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident admitted to geri psych hospital on 1.30.23 for medication review. Resident readmitted to community with one on one sitter on. Resident will continue to have one on one care until exit seeking behaviors are resolved. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All ambulatory residents have the potential to be affected by alleged deficient practice. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Community will install wooden window stops in addition to manufacturer installed window stops to every exterior window in the community.	03/06/2023

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	go outside. Resident compliant with medications, good appetite and fluid intake, minimal assist with ADL's (Activities of Daily Living). Will continue to monitor, VSS (vital signs) ...." A nurses' note, dated 01/17/2023 at 9:50 p.m., indicated "...Alert Charting Note...Resident continues on f/u new admit, exit seeking behavior noted this evening. Resident easily redirected...Will continue to monitor and encourage activities to keep resident engaged...." A nurses' note, dated 01/19/2023 at 2:01 p.m., indicated "...Alert Charting Note...new admit note--resident up walking halls, looking for something to do, wants to know where everyone is. let her know it was 11 pm and everyone was in bed asleep and she should get some sleep also...." A nurses' note, dated 01/20/2023 at 9:37 p.m., indicated "...Alert Charting Note...Resident having exit seeking behaviors early in shift, picking up belongings that do not belong to her, annoying other residents and staff throughout shift. Resident needs monitored to ensure she is not giving care or transferring residents...." A nurses' note, dated 01/22/2023 at 9:41 p.m., indicated "...Alert Charting Note...Re (resident) exit seeking this evening. Res trying doors, and attempting to use keypads to open locked doors. Res also found attempting to open windows and unlock widows. Res found downstairs in other res rooms. Res brought back upstairs and elevator was shut down. Res having a hard time settling down. needs 1 on 1 for assurance...." A nurses' note, dated 01/25/2023 at 9:50 p.m., indicated "...Alert Charting Note...Res exit seeking. Res using elevator and opening door to		· How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Maintenance Director or designee will complete monthly inspections to windows and window stops. Inspections will be documented in work order system. · By what date the systemic changes will be completed. Window stops to be installed no later than March 6, 2023.	

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	unit. Write found plyers (pliers) wrapped in res blanket. Res would not state where she got plyers (pliers) from...." A nurses' note, dated 01/29/23 at 9:09 p.m., indicated "...Alert Charting Note...Can't locate resident this afternoon (around 4:30 p.m.) after searching all the rooms in this facility. Executive director & DON & 911 in building after called by this writer. Family informed. Res was found and sent to hospital with a family member accompanied at this time per DON (Director of Nursing)...." A facility document, titled "INCIDENT INVESTIGATION," dated 01/29/23, addressed the elopement. An interview from the incident investigation form indicated LPN 1 saw the resident around 4:00 p.m. At 5:00 p.m., LPN 1 attempted to locate the resident but was unable to do so. The elopement protocol was activated. The timeline, from the incident investigation form indicated: 3:30 p.m., resident was in the bistro area 3:45 p.m., resident was in the piano room 4:30 p.m., LPN 1 was unable to find the resident, the Executive Director, POA and 911 were activated. 5:34 p.m., Executive Director and nursing staff located a broken window lock and screw in the ledge of the piano room window. 8:00 p.m., resident was found by police east of 116th street and Keystone, approximately 1.6 miles from the community. EMS (emergency medical services) assessed the resident and transported her to the hospital. 11:57 p.m., the resident returned to the community with a 1 on 1 sitter.			

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	During an interview, on 02/03/2023 at 10:20 a.m., the Executive Director indicated the resident was transferred to a psych hospital. At that time, the Director of Nursing indicated she transferred out on Monday, January 30, 2023. During an interview, on 02/03/2023 at 11:19 a.m., the Director of Nursing indicated the facility did not do any elopement risks on any residents, they are all at risk if they are ambulatory. During an interview, on 02/03/2023 at 11:19 a.m., the Executive Director indicated the facility found out there was an elopement, at 4:43 p.m., which was when they called 911. The police were out looking for the resident from 5:00 p.m., to 8:00 p.m. The police found the resident east of Keystone Parkway. The Emergency Medical Services Unit assessed her and took her to the hospital, she returned to facility at 11:57 p.m. Upon her return to the facility, they had a one-on-one aide already in the facility waiting for the resident. The one-on-one aide remained with the resident until 5:34 p.m., on Monday 01/30/23. A facility policy, titled "Abuse, Neglect & Exploitation Policy," dated as revised in 5/2021 and provided by the Director of Nursing on 02/03/2023 at 2:45 p.m., indicated "...Neglect...an act or omission which places a resident in a situation that may endanger the resident's life or health...." This State tag relates to Complaint IN00400382.			