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	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MEADOW BROOK SENIOR LIVING	11011 VILLAGE SQUARE LANE FISHERS, IN 46038

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00437607. Complaint IN00437607 - State deficiencies related to the allegations are cited at R0052. Survey date: July 8, 2024 Facility number: 013163 Residential Census: 87 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 15, 2024.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview, and record review, the facility failed to ensure a resident (Resident B) was free from neglect by not ensuring adequate supervision was provided to prevent elopement. This deficient practice resulted in Resident B being assisted by staff to exit the facility to the exterior courtyard without supervision and the resident successfully exited the courtyard without the gate alarm effectively alerting staff. Findings include: An Incident Report, dated 6/27/24 at 6:01 p.m., indicated Resident B exited the Memory Care Unit (MC) through the courtyard fence door. The	R 0052	What corrective action(s) will be accomplished for those residents found to have been affected by thedeficient practice; No Negative outcome identified for the resident that was affected. •How the facility will identify other residents having the potential to be affected by the same deficientpractice and what corrective action will be taken; All residents had the potential to be affected. No residents were adversely affected. •What measures will be put into place or what systemic changes the facility will make to ensure	07/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	immediate action taken was "Wellness staff member was in MC dining room with a view of the courtyard when at 5:59 pm [sic, p.m.] another memory care resident signaled to staff that courtyard exit door was open. CNA [sic, Certified Nursing Assistant] immediately notified MCD [sic, memory care director] and ED [sic, Executive Director] who were in common space of Memory Care. All 3 staff members proceeded out the courtyard exit and saw resident walking on the sidewalk on the side of the community. Resident was re-directed and brought back inside community at 6pm [sic, 6:00 p.m.]. Resident assessed, [sic] and not injuries noted...Resident continued to attempt to exit unit and struck ED in face multiple times." Preventive measures included, but were not limited to, notify Resident B's physician and the Power of Attorney, family came to facility and provided one on one care until sent to a Psychiatric hospital for exit seeking and aggression. An observation of the facility's memory care door exit alarms was conducted, on 7/8/24 at 2:20 p.m., with ED (Executive Director), maintenance staff member, and DON (Director of Nursing). The DON and maintenance staff member went out into the courtyard and pushed on the gate bar to open the gate. ED remained inside the facility with the door from the dining room to the courtyard closed. After opening the gate, the ED indicated the courtyard exit gate alarm was difficult to hear from inside the facility when activated and would be more difficult for staff to hear in the presence of additional noise. The clinical record for Resident B was reviewed on 7/8/24 at 10:21 a.m. Resident B's diagnoses included, but were not limited to, Alzheimer's disease, dementia with severe mood disturbance,		that thedeficient practice does not recur; Memory Care Director or designee will complete staff education and in-services on MC door alarm system process and procedure and resident supervision. The Memory Care Director or designee will conduct monthly risk assessments to identify those who are most at risk of elopement-monthly x3 months, then every 6 months after. Executive Director will complete an audit with the manufacturer and confirm the gate/alarm system works effectively. Facility will add additional alarm to interior of MC unit to sound when MC gates are opened during gate locked hours. •How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place; and The Memory Care Nurse or their designee will conduct daily audits to ensure that the courtyard and gate doors are locked/unlocked at the appropriate times- daily x1 month, then weekly x 3 weeks, then monthly on-going. The Memory Care Director or designee will conduct monthly risk assessments to identify those who are most at risk of elopement-monthly x3 months, then every 6 months after. •By what date the systemic changes will be completed.	

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	anxiety, and depression. Resident B was admitted to the facility on 4/16/24. Resident B's initial Service Plan, dated 4/2024, indicated she had a poor remote and recent mental status and indicated she required assistance with orientation. Interventions included, but were not limited to, for staff to provide encouragement and simple information about the day, time and location. The Service plan did not indicate Resident B had exit seeking behaviors in the past. Resident B's Service Plan, dated 4/23/24, did not indicate she had exit seeking behaviors. The nursing notes indicated Resident B exhibited 10 episodes of exit seeking behavior between 4/17/24 and 5/9/24 as follows: - 4/17/2024 at 9:09 p.m., indicated Resident B appeared to be "sundowning" (a neurological phenomenon associated with increased confusion and restlessness in people with some form of dementia) and wanted to get out of the facility. This progress note did not contain what/if any interventions were implemented to prevent further elopement attempts. - 4/18/24 at 9:18 p.m., indicated Resident B was on every 15 minute checks related to exit seeking and continued to walk the hallways. No further progress notes from that day indicated any other interventions were attempted to prevent Resident B from exit seeking. - 4/19/24 at 2:12 p.m. indicated Resident B was "trying to leave" and stated, "I need to go to the store". The note indicated Resident B was redirected at that time. The note did not indicate any further interventions had been attempted		7/26/2024	

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	other than redirection. - 4/19/24 at 8:42 p.m. indicated Resident B was on 15 minute checks as the resident continued to exit seek and was pacing on the unit. The progress note did not indicate any further interventions had been attempted to prevent the exit seeking behavior or to prevent the resident's pacing. No further behavioral notes were noted for that day. - 4/20/24 at 5:04 a.m. indicated Resident B remained on 15 minute checks related to exit seeking behaviors from the previous day. No behaviors were noted at that time. No further progress notes indicated any further interventions were attempted as resident "slept through the night". - 4/23/24 at 9:06 p.m., indicated Resident B "Appeared To Be Very Anxious Exit Seeking" and indicated she did not believe her family brought her to the facility. Facility staff called Resident B's daughter and requested she, or someone else Resident B was familiar with, could come and see the resident in an attempt to decrease her exit seeking behavior. The progress note did not indicate if the intervention worked or if someone came to sit with the resident. - 4/25/24 at 6:36 p.m. indicated a new order for Clonazepam (an anti-anxiety medication) 0.5 mg (milligrams) was to be given to Resident B for agitation. The note did not indicate what behaviors Resident B was exhibiting nor did it indicate what other non-pharmacological interventions had been attempted previously that day. - 4/27/24 at 8:56 p.m. indicated Resident B appeared to be very anxious after dinner and was			

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	given a dose of PRN (as needed) Clonazepam. The note did not indicate what/if any other non-pharmacological interventions had been attempted to decrease the resident's anxiety. - 4/28/24 at 8:30 p.m., indicated Resident B wanted out of the facility and to call her husband. Resident B "Kept Trying to Get Out." The progress note did not include what/if any interventions were attempted to prevent the resident's exit seeking behavior nor what the resident was doing to keep trying to get out. The progress note did not indicate that any additional interventions were added to Resident B's service plan at that time. - 4/29/24 at 8:23 p.m., indicated Resident B "...continues seeking to exit the unit, setting off the alarm on many occasions. Resident became upset and confrontational with staff for not opening the door for her to leave...daughter was notified by this nurse concerning resident's behavior and continuously seeking to leave...". The progress note did not indicate what interventions were attempted nor did it indicate any new interventions had been added to the resident's care plan. The progress note did not include documentation to show what interventions were attempted to prevent elopement, if any interventions were effective or not, and what/if any new intervention was attempted. No further progress notes regarding exit seeking behavior were noted that day. - 4/30/24 at 12:27 p.m., indicated Resident B had a new order for Depakote sprinkles (medication used to treat seizure disorders, certain psychiatric conditions and prevents migraine headaches) to be given twice daily and for Clonazepam 0.5 mg daily.			

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	- 5/1/24 at 9:26 p.m., indicated Resident B was exit seeking and trying to leave after her daughter had visited that day. Resident B kept saying she wanted out. The progress note indicated Resident B was on 15 minute checks and finally took her medication. She later calmed down and went to sleep. The progress note did not include documentation to show what/if any other interventions were attempted to prevent elopement other than the 15 minute checks and medications given. No further progress notes regarding exit seeking behavior were noted that day. - 5/3/24 at 10:18 p.m., indicated Resident B was anxious and exit seeking. The progress note did not include documentation to show what interventions were attempted to prevent elopement, if any interventions were effective or not, and what/if any new intervention was attempted. No further progress notes regarding exit seeking behavior were noted that day. - 5/5/24 at 1:37 p.m., indicated Resident B was exit seeking, had packed her clothes in a plastic bag and was wandering the unit. Resident B pushed at the door seeking to exit and set off the door alarm. Resident B was unable to be redirected. The progress note did not include documentation to show what/if any new intervention was attempted. No further progress notes regarding exit seeking behavior were noted that day. - 5/6/24 at 10:14 a.m., indicated Resident B was seeking to exit the building and set the door alarms off. Resident B was restless and wandering around the unit with a plastic bag in her hands. Resident B indicated she wanted to go out and deliver clothes to her friend. Staff			

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	redirected the resident to the common area and gave her a PRN Clonazepam. The note did not indicate if the interventions were effective. - 5/9/24 at 9:12 p.m., indicated Resident B was wandering the unit and exit seeking. Resident B indicated she wanted to call her husband. The progress note did not include documentation to show what interventions were attempted to prevent the exit seeking behavior or elopement, if any interventions were effective or not, and what/if any new intervention was attempted. No further progress notes regarding exit seeking behavior were noted that day. No further progress notes from 5/8/24 until 5/12/24 contained exit seeking behaviors. A Change in Condition service plan, dated 5/13/24, indicated Resident B was cognitively impaired and wandered with exit-seeking behaviors. The plan indicated Resident B required monitoring for wandering but did not require regular safety checks. The plan included interventions for staff to redirect the resident to the correct location in the building, staff to assist with orientation and redirection as needed, and staff to intervene accordingly when resident exhibited behaviors. The service plan did not include documentation of specific interventions staff should attempt to prevent elopement. The nursing notes Resident B exhibited 15 episodes of exit seeking behaviors between 5/13/24 and 6/25/24 as follows: - 5/13/24 at 9:48 a.m., indicated Resident B had a fall. Resident B was restless and wandering around the unit exit seeking. A PRN Clonazepam was administered, and the facility encouraged the resident to sit down and rest as her balance was			

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	unsteady. The note did not include documentation to show if the interventions were effective and/or what new intervention was attempted. - 5/13/24 at 7:46 p.m., indicated Resident B was exit seeking and set off the door alarm because she needed to look for her dog and car. Resident B was given Clonazepam for restlessness and agitation and was reassured her car and dog were with family. The note did not include documentation to show if the interventions and if they were not effective and/or what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 5/15/24. - 5/15/24 at 2:37 p.m., indicated Resident B was exit seeking and the intervention was redirection and was placed on 15 minute checks. The note did not include documentation to show what interventions were attempted to prevent elopement, if they were effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 5/22/24. - 5/22/24 at 8:49 a.m., indicated Resident B was exit seeking and set off the door alarm. Resident B was placed on 15 minute checks and given Clonazepam PRN. The note did not include documentation to show what interventions were effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 5/25/24. - 5/25/24 at 9:01 a.m., indicated Resident B was exit seeking and dragging her laundry basket trying to exit the unit and setting off the door alarms twice.			

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	Re-direction was not successful as she kept asking for her husband. She was placed on 15-minute checks and was administered the PRN Clonazepam for restlessness and agitation. The note did not include documentation to show what interventions were effective and, if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/3/24. - 6/3/24 at 7:21 p.m., Resident B attempted to exit the unit by pushing on the exit door and set off the door alarm. Resident B was asking for her daughter, then said she wanted to cross the road to the pharmacy store. She was asked by staff what she wanted to purchase at the store but refused to tell the staff. The note indicated she remained restless and was also wandering into other resident's rooms while she continued to ask for her daughter. Fifteen-minute checks were started, and her nighttime medications were administered. The note did not include documentation to show if the interventions that were used were effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/5/24. - 6/5/24 at 10:35 a.m., indicated "Resident is exit seeking, set off door alarm at about 10:30am [sic]. Resident is redirected to the common area, and she attempted to push another door." The note indicated Resident B was placed on 15-minute checks. The note did not include documentation to show any other interventions that were attempted to prevent elopement, if they were effective, and if they were not effective, what new intervention was attempted. - 6/5/24 at 1:59 p.m., indicated "Resident attempted			

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	to exit the door." Resident B was redirected to the common area and remained on 15-minute checks. The note did not include documentation to show if the interventions attempted to prevent elopement were effective and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/7/24. - 6/7/24 at 6:01 p.m., indicated "Writer noted [sic, Resident B] exit seeking near the right wing exit on unit". Resident B was redirected to the common area and 15-minute checks in place. The note did not include documentation to show what interventions were effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/10/24. - 6/10/24 at 7:19 p.m. indicated Resident B was wandering around the unit and telling staff that she wants to get out. Resident B was administered a PRN Clonazepam. The note did not include documentation to show what other non-pharmacological interventions were attempted prior to administering a medication to prevent elopement, if it was effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/12/24. - 6/12/24 at 1:28 p.m., indicated "Resident is on 15 min [sic, minute] safety check d/t [sic, due to] seeking to exit the unit. Resident [sic, Resident B] is restless and asking staff to let her out". Resident B becomes upset that staff do not assist her in leaving the building. A scheduled Clonazepam was administered. The note did not include documentation to show what other non-pharmacological interventions were			

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	attempted prior to administering a medication to prevent elopement, if it was effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/15/24. -6/15/24 at 10:16 a.m. indicated Resident B was wandering the hallways on the unit went she attempted to exit through the left-wing door. Resident B was redirected to the common area. The 15-minute checks were in progress. The note did not include documentation to show what interventions were effective, and if not effective, what new intervention was attempted if it was effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/17/24. - 6/17/24 at 1:56 p.m. indicated Resident B remained on 15-minute checks due to exit seeking. No additional progress notes indicating exit seeking behaviors were noted until 6/19/24. - 6/19/24 at 11:47 a.m., indicated "Resident noted seeking to exit the right wind door, setting the alarm off..." Resident B was redirected to the common area but continued to wander the unit. The 15-minute check was in place. The note included documentation to show the redirection intervention was not effective, but failed to document a new intervention that should have been attempted if it was effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/22/24. - 6/22/24 at 1:22 p.m., indicated "Resident is placed on 15 min [sic] check d/t[sic] exit seeking, setting off the door alarm. Resident is wandering around			

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	asking staff to [sic] lead her out of the building". The note did not include documentation to show if the interventions attempted to prevent elopement were effective and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/23/24. - 6/23/24 at 1:09 p.m., indicated "Resident is exit seeking, set off the main entrance unit door alarm." Resident B was redirected and was on 15-minute checks. The note did not include documentation to show what interventions were effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/24/24. -6/24/24 at 1:26 p.m. indicated Resident B set off the door alarm exit seeking. She was redirected to the courtyard to sit with the rest of the residents. The note did not include documentation to show if the intervention was effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/25/24. - 6/25/24 at 1:13 p.m., indicated "Resident is noted restless and wanders the unit...seeking to exit the unit and asking staff why she cannot go out. Staff continues to redirect the resident and monitors d/t [sic] exit seeking. The note did not include documentation to show which/if any of the interventions were effective, and if not effective, what new intervention was attempted. - 6/25/24 at 9:23 p.m., indicated "Resident is noted agitated, restless and wanders the unit, seeking to exit the unit and asking staff why she cannot go out. Resident sound [sic, sounded] off the door			

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	alarm closest to her room x2 [sic, twice] this shift." The note did not include documentation to show which/if any of the interventions were effective, and if not effective, what new intervention was attempted. No further progress notes regarding exit seeking were noted until 6/26/24. - 6/26/24 at 8:40 a.m. indicated Resident B was administered PRN Clonazepam for restlessness and agitation. Resident B was wandering into another resident's room. The note did not include documentation to show what other non-pharmacological interventions were attempted prior to administering a medication to prevent elopement, if it was effective, and if not effective, what new intervention was attempted. No additional progress notes indicating exit seeking behaviors were noted until 6/27/24 when Resident B had eloped from the facility. The facility's investigation file regarding Resident B's elopement incident, on 6/27/24, was received on 7/8/24 at 1:46 p.m. The investigation file contained a summary of the investigation and a written statement from Certified Nursing Assistant (CNA) 3. The investigation summary indicated CNA 3 had opened the door from the dining room to the courtyard to let Resident B outside per her request. The courtyard was fenced in and had two gates to the outside. In Licensed Practical Nurse (LPN) 3's statement, he indicated, he was in the dining room when Resident B requested to go outside in the courtyard. After letting Resident B out, another resident sitting in the courtyard signaled to CNA 3 and pointed to the open courtyard gate. Resident B was found outside of the courtyard walking on the sidewalk on the side of the building. The investigation report did not indicate if the gate door alarm was sounding when staff went to find Resident B.			

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	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	An interview with LPN 2 conducted, on 7/8/24 at 2:20 p.m., indicated when a resident was outside in the courtyard, a staff member was to be present. He stated, Resident B liked to wander the unit and would exit seek so when she was out wandering a staff member needed to be within direct visual contact of her. He indicated; no planned activities occur after dinner on the memory care unit. An interview with the ED, on 7/8/24 at 3:16 p.m., indicated when a door alarm goes off in the memory care unit, that door alarms and a pager the staff members wear, goes off. ED was asked when she had questioned CNA 3 about the incident, had she asked him if he was wearing the pager the day/time Resident B had eloped from the facility, she indicated, she had not asked CNA 3 that question nor had she asked him if he heard the courtyard gate alarm alarming at that time. An interview with CNA 3 conducted, on 7/8/24 at 3:20 p.m., indicated Resident B's family had visited earlier in the day and brought a family member she had not seen since being at the facility. He indicated he knew Resident B would get "triggered" to exit seek after she had visits from family or friends. CNA 3 indicated he was inside the facility, by the door from the dining area into the courtyard and Resident B was outside in the courtyard. He was busy and when he looked up to the courtyard, he saw another resident in a wheelchair wheeling themselves to the door. He indicated he thought they just needed assistance with opening the door to come into the building however, that resident said to him, "that lady gone". CNA 3 looked for Resident B in the courtyard, but she was nowhere to be seen and a wooden gate was left open. CNA 3 indicated he did not hear the gate alarm going off. He			

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	indicated he was not aware that a staff member needed to be outside with the residents were in the courtyard. CNA 3 indicated, when a staff member disarms the door from the dining room to the courtyard, it also disarmed the wood gates in the courtyard. An interview with Regional Nurse Consultant (RNC) conducted, on 7/8/24 at 3:56 p.m., indicated the door from the dining room to the courtyard and the courtyard gate alarms were set so that in the summertime, after 6:00 p.m., those two exits (one being from the dining room into courtyard and other being the wood gates in the courtyard) could not be locked and armed at the same time. So, in the summer, after 6:00 p.m., the facility doors to the community lock but then the wood gates are unlocked. RNC did not indicate how Resident B was able exit the courtyard at 5:59 p.m. when the gates should have been locked and armed. On 7/8/24 at 10:14 a.m., the ED provided a Policy and Procedure for Elopement/Missing Resident. The policy indicated the following, "It is the policy of this facility that personnel who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, appropriate action is taken." The policy did not detail procedures to define the mechanisms and procedures for assessing, identifying, monitoring, and/or managing residents at risk for elopement nor was the facility able to provide a Behavior Management Policy. This tag relates to Complaint IN00437607.			