| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155683 | A. BUILDING 00<br>B. WING | 07/03/2017 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00233570.<br><br>This visit resulted in a Partially Extended Survey-Substandard Quality of Care-Immediate Jeopardy.<br><br>Complaint IN00233570- Substantiated. Deficiencies related to the allegations are cited at F273, F276, F279, and F323.<br><br>Survey date: June 30, 2017<br><br>Extended survey dates: July 1, 2, and 3, 2017<br><br>Facility number: 011032<br>Provider number: 155683<br>AIM number: 200262860<br><br>Census bed type:<br>NF: 16<br>SNF/NF: 7<br>Total: 23<br><br>Census payor type:<br>Medicaid: 23<br>Total: 23<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC | F 0000 | Please accept this as our credible allegation of compliance. | |

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

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| | 16.2-3.1.<br><br>Quality review completed on July 7, 2017 | | | |
| F 0273<br>SS=D<br>Bldg. 00 | 483.20(b)(2)(i)<br>COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT<br>(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br><br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>Based on record review and interview, the facility failed to ensure an initial comprehensive assessment was completed within 14 days of admission, as required by regulation and facility policy. 1 of 3 residents reviewed for initial assessment. (Resident B).<br><br>Findings include:<br><br>The record of Resident B was reviewed on 6/30/17 at 10:00 A.M. Diagnoses | F 0273 | Resident B did not have a 14 day assessment. This was due to the MDS Coordinator being ill. The 14 day assessment has been completed and filed in the resident's closed folder.<br><br>No other residents were found to be affected by this deficient practice. There were no other new admissions.<br><br>An admissions book to keep track of all 14 day assessments has been | 08/02/2017 |

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| | included, but were not limited to, a history of traumatic brain injury, amnesia, mood disorder (unspecified), personality disorder (unspecified), anxiety disorder, delusions, ADHD (attention deficit hyperactivity disorder), gastro-esophageal reflux disease, and encephalopathy (damage to the brain.)<br><br>Resident B was admitted to the facility on 5/24/17. His record did not contain a completed Minimum Data Set (M.D.S.) comprehensive assessment.<br><br>On 7/03/17 at 11: 30 A.M., the Social Services Director (SSD) indicated there was no completed comprehensive assessment for Resident B. The SSD indicated completing the comprehensive assessment was the responsibility of the M.D.S. Coordinator, who had been unavailable due to illness.<br><br>An undated facility policy titled "Comprehensive Assessment/MDS Policy" received from the SSD on 7/03/17 at 1:25 P.M., indicated: "Purpose: To define the responsibilities of each health care discipline for the completion of the comprehensive assessment instrument (known as the MDS) and for ongoing monitoring of each resident's health status. Responsibility: Director of | | created. All new admissions will be put into this book along with the admission date and the date when the 14 day assessment is due. All new admissions will be placed in this book by the admitting nurse. This book will be kept at the Nurse's Station at all times.<br><br>The Social Services Director will be in charge of the admissions book. The Social Services Director will monitor all new admissions and alert the MDS Coordinator and the D.O.N. to when all 14 day assessments are due. A new admissions audit sheet has been created and added to the admissions book.<br><br>With this sheet, the Social Services Director will audit the admissions book weekly for 2 months, then bi-weekly for 4 months for a total of 6 months, and from there it will be monitored monthly on an ongoing basis. This process will be re-implemented for all new admissions. The QA Committee will monitor this process quarterly to ensure the program's effectiveness and that it is being followed.<br><br>The Admission's Book and all 14 day assessments for new admissions will also be monitored for effectiveness by the D.O.N. and the Administrator on an ongoing basis. An inservice on new admissions policies was completed on 07/28/2017. | |

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| | Nursing...MDS Coordinator...Social Service Director...Policy: It is the policy of B and B Christian Health Care Center to perform a comprehensive, accurate, standardized, reproducible assessment of each resident's status following admission and at least annually and quarterly thereafter in order to obtain information vital to the development of the resident's plan of care. Standards: 10. A registered nurse shall be designated as the R.N./MDS Coordinator and shall verify the completion of the assessment form within fourteen days of admission..."<br><br>This Federal tag relates to Complaint IN00233570.<br><br>3.31(d)(1) | | | |
| F 0276 SS=D Bldg. 00 | 483.20(c)<br>QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS<br>(c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>Based on record review and interview, the facility failed to ensure quarterly comprehensive assessments (Minimum Data Set Assessments) were completed | F 0276 | The quarterly assessments for Residents C & D are currently being completed by the MDS Coordinator and will be put into place. | 08/02/2017 |

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| | for 2 of 3 residents reviewed for quarterly assessments. (Residents C and D).<br><br>Findings include:<br><br>The record of Resident C was reviewed on 7/03/17 at 11:00 A.M. Diagnoses included, but were not limited to, dementia with behaviors, schizophrenia, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, and insomnia.<br><br>A quarterly Minimum Data Set (M.D.S.) assessment dated 2/24/17 indicated Resident C was cognitively impaired, required little or no staff assistance with activities of daily living, and was able to ambulate independently.<br><br>Resident C's record contained no M.D.S. assessment more recent than 2/24/17. A target date for completion of a quarterly M.D.S. would have been 5/25/17.<br><br>On 7/03/17 at 1:55 P.M., the Social Services Director provided an incomplete, undated M.D.S. for Resident C. The SSD indicated completing the quarterly M.D.S. assessment was the responsibility of the M.D.S. Coordinator, who had been unavailable due to illness.<br><br>The record of Resident D was reviewed | | All the charts were audited for delinquent quarterly MDS'. All MDS' will be brought current.<br><br>We have contracted with an MDS Coordinator to work on an "as needed" basis. She will fill in when the regular MDS Coordinator is unavailable. Due to the MDS Coordinator's illness, she was unable to keep the MDS' current. With a new contracted "as needed" MDS person, this will ensure that there will always be an MDS Coordinator available to enter the MDS'.<br><br>A monthly MDS schedule will be created by the MDS Coordinator or the "contracted" MDS Coordinator and given to the D.O.N.and Social Services Director, both of whom will monitor the schedule along with resident's charts for any upcoming quarterly assessments. A new MDS monitoring form has been created, which the D.O.N. & Social Services Director will use to monitor the MDS schedule daily for 2 weeks and weekly thereafter on an ongoing basis.<br><br>The Administrator will also monitor the MDS schedule on a monthly basis. The QA Committee will monitor this overall process on a quarterly basis to ensure its effectiveness and that the process is being followed. An inservice on the MDS schedule and completion dates | |

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| | on 7/03/17 at 1:00 P.M. Diagnoses included, but were not limited to, behaviors with aggression, Alzheimer's Dementia, dementia with psychosis, alcohol abuse, hypertension, depression, and anemia.<br><br>A quarterly Minimum Data Set (M.D.S.) assessment dated 1/12/17 indicated Resident D was unable to complete the Basic Interview for Mental Status interview, was indicated by staff to be severely cognitively impaired, required extensive staff assistance with activities of daily living, and did not ambulate independently.<br><br>Resident D's record contained no M.D.S. assessment more recent than 1/12/17. A target date for completion of a quarterly M.D.S. would have been 4/12/17.<br><br>On 7/03/17 at 1:55 P.M., the Social Services Director provided an incomplete, undated M.D.S. for Resident D. The SSD indicated completing the quarterly M.D.S. assessment was the responsibility of the M.D.S. Coordinator, who had been unavailable due to illness.<br><br>An undated facility policy titled "Comprehensive Assessment/MDS Policy" received from the SSD on 7/03/17 at 1:25 P.M., indicated: | | was given to the MDS Coordinator, Social Services Director, the Dietary consultant, and the Administrator on 07/28/2017. | |

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| | "Purpose: To define the responsibilities of each health care discipline for the completion of the comprehensive assessment instrument (known as the MDS) and for ongoing monitoring of each resident's health status. Responsibility: Director of Nursing...MDS Coordinator...Social Service Director...Policy: It is the policy of B and B Christian Health Care Center to perform a comprehensive, accurate, standardized, reproducible assessment of each resident's status following admission and at least annually and quarterly thereafter in order to obtain information vital to the development of the resident's plan of care. Standards: 10. A registered nurse shall be designated as the R.N./MDS Coordinator and shall verify the completion of the assessment form within fourteen days of admission...annually, and upon significant change and quarterly."<br><br>This Federal tag relates to Complaint IN00233570.<br><br>3.31(d)(3) | | | |
| F 0279 | 483.20(d);483.21(b)(1) | | | |

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| SS=D<br>Bldg. 00 | DEVELOP COMPREHENSIVE CARE PLANS<br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR | | | |

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| | recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. | | | |
| | Based on record review and interview, the facility failed to develop care plans for 1 resident with a known risk for elopement (Resident B), and for 1 resident with behaviors (Resident D) for 2 of 3 residents reviewed for care plans.<br><br>Findings include:<br><br>The record of Resident B was reviewed on 6/30/17 at 10:00 A.M. Diagnoses included, but were not limited to, a history of traumatic brain injury, amnesia, mood disorder (unspecified), personality disorder (unspecified), anxiety disorder, delusions, ADHD | F 0279 | Resident B was discharged to another facility on June 30, 2017. The assessment and care plan were not in place at that time. His chart since then has been completed and closed out by the Social Services Director.<br><br>Other resident's charts have been audited for care plans and are currently being updated with appropriate care plans.<br><br>The Social Services Director will oversee the care plan process to ensure all care plans are created. The Social Services Director will audit all resident's care plans weekly for 2 months, then bi-weekly for 2 | 08/02/2017 |

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| | (attention deficit hyperactivity disorder), gastro-esophageal reflux disease, and encephalopathy (damage to the brain.)<br><br>Resident B's record did not contain a completed Minimum Data Set (M.D.S.) assessment.<br><br>Documentation in Resident B's record obtained from his previous facility at the time of his admission to the current facility and available to the facility for review and evaluation included:<br><br>Report of Neuropsychological Testing dated 3/28/17: "... Staff also related that (Resident B) presents an 'elopement risk' as he has left the facility without leave in the past, including at least one incident of having walked alone to his (family member's) residence toward downtown Indianapolis...'in the middle of the night.' Resident now wears a Wanderguard (an electronic device which sets off a warning signal when the wearer approaches an exit) to indicate proximity to exits."<br><br>Comprehensive Psychiatric Evaluation dated 4/25/17: "This is a (description of Resident B) who has been admitted for delusions, agitation, and bizarre behaviors...with a history of dementia. He apparently, on a recent occasion...became | | months, and then monthly thereafter on an ongoing basis.<br><br>The MDS Coordinator will give the Social Services Director a monthly MDS & Care Plan schedule which shows all upcoming MDS & Care Plan dates.<br><br>The D.O.N. and Administrator will follow up and monitor this process on a monthly basis. The QA Committee will monitor the MDS & Care Plan schedule on a quarterly basis to ensure their effectiveness and that the process is being followed. An inservice on the MDS & Care Plan schedule was given to the MDS Coordinator, the Social Services Director, the Dietary consultant, and the Administrator on 07/28/2017. | |

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| | agitated...and exited the building making it out to the parking lot...he also became very agitated and confrontational with staff...he has been pacing and restless..."<br><br>Medical History and Physical dated 4/25/17: "(Description of Resident B)...who was evaluated at (his previous facility) for recently having some delusions...He had increased anxiety since this and a significant amount of exit seeking recently..."<br><br>An undated Risk For Elopement, believed to be from Resident B's admission to his previous facility on 12/22/16, indicated "yes" answers to the questions:<br><br>"1. Is resident physically able to leave the building on their own?<br><br>2. Is the resident cognitively impaired? If 1 and 2 are marked yes, proceed to questions 3-8.<br><br>3. Does the resident have impaired decision making skills.?<br><br>If "Yes" is marked for #1 and 2 and any other (#3-8), consider a prevention plan of care for elopement."<br><br>The assessment included a hand written | | | |

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| | note "Wanderguard LLE (left lower extremity.)"<br><br>A Medication Review Report dated May 1 2017 included the order "Check Wanderguard placement to L (left) ankle every shift. Order status: Active. Order date: 12/22/2016. Start date: 12/22/2016."<br><br>Resident B's record did not contain a health care plan for the risk for elopement prior to his elopement from the facility on 6/22/17. An undated Comprehensive Care Plan with an identified need of "The resident demonstrates movement behavior that may be interpreted as wandering, pacing or roaming..." was identified by the Social Services Director (SSD) as having been created after Resident B's elopement from the facility.<br><br>The record of Resident D was reviewed on 7/03/17 at 1:00 P.M. Diagnoses included, but were not limited to, behaviors with aggression, Alzheimer's Dementia, dementia with psychosis, alcohol abuse, hypertension, depression, and anemia.<br><br>A quarterly Minimum Data Set (M.D.S.) assessment dated 1/12/17 indicated Resident D was unable to complete the | | | |

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| | Basic Interview for Mental Status interview, was indicated by staff to be severely cognitively impaired, required extensive staff assistance with activities of daily living, and was did not ambulate independently.<br><br>Nurse's Notes for Resident D included: 2/17/17 (Time not noted): "Res (resident) up in w/c (wheel chair) (symbol for "with") assistance X2 (times 2) uncooperative a (sic) this time..." 3/29/17 (Time not noted): "Res up in w/c per staff...agitated a (sic) combative a (sic) times..." 4/05/17 10:10 A.M.: "...communicates verbally will not answer questions appropriately (symbol for "at") X's (times)...May become agitated at X's especially on shower days..." 5/17/17 (No time noted): "Res up in w/c...at times very uncooperative can be combative..." 6/14/17 (No time noted): "Res up in w/c per staff Res easily agitated..."<br><br>Resident D's record did not contaion a health care plan for issues of non-cooperation, agitation, aggression, or combative behavior.<br><br>On 7/03/17 at 1:30 P.M., the SSD indicated the facility had no separate system for identifying and tracking resident behaviors, and all such | | | |

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| | documentation would be in the health care plan in the resident's record.<br><br>An undated facility policy titled "Care Plans (Resident Care Planning) received from the SSD on 7/03/17 at 10:20 A.M., indicated: "Purpose: To promote individualized resident care plan (sic) with specific plans from nursing and other disciplines....To provide continuity of care...To provide guidance in documentation in nursing progress notes...<br>Resources: Resident Assessment System, including the MDS and RAP's...Clinical Record...Interdisciplinary or intradisciplinary team members...Procedure: Charge nurse initiates at time of admission...The Comprehensive Assessment shall be performed to identify needs problems, goals, based on assessed needs...The Director of Nursing/Designee shall coordinate the care planning activities for all disciplines...Personnel on all shifts are responsible for adding new needs or problems and approaches...The care plan will be kept in a binder at the nurses (sic) station or with the Medical Record."<br><br>This Federal tag relates to Complaint IN00233570.<br><br>3.1-35(a) | | | |

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| F 0323 SS=J Bldg. 00 | 483.25(d)(1)(2)(n)(1)-(3)<br>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>Based on record review and interview, the facility failed to ensure assessment, | F 0323 | A risk assessment was immediately put in place on the resident who eloped. An elopement care plan | 08/02/2017 |

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| | supervision, and safety interventions were implemented to prevent the elopement of a resident who was a known elopement risk. One of three residents reviewed for elopement risk assessment. (Resident B)<br><br>The Immediate Jeopardy began on 06/22/17 at 3:00: P.M., when Resident B was noted to be absent from the facility by the Social Services Director. The Director of Nursing and Social Services Director were notified of the Immediate Jeopardy at 1:00 P.M., on 06/30/17. The Immediate Jeopardy was removed on 07/03/15 at 1:00 P.M. but noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>On 6/30 2017 at 10:05 A.M., the Social Services Director (SSD) indicated that on 6/22/17 at approximately 3:00 P.M., while preparing for an activity in the facility dining room, she noted Resident B was not visible in the area outside used by residents for smoking. Residents who smoke were being supervised by CNA #1. She indicated Resident B did not smoke but often went outside when other residents did. She indicated at that time | | was also put in place. All staff have been made aware that the resident is an elopement risk.<br><br>A new Elopement Policy was put in place. All staff will be immediately inserviced on the new Elopement Policy. When resident returned to the facility, 15 minute checks were implemented for 24 hours and then hourly checks for another 24 hours to ensure the resident's safety.<br><br>All residents had the potential to be affected by this deficient practice but none were identified. All residents were assessed for any potential elopement risk. All staff were inserviced on all potential elopement risk residents. Per evaluation, none were found to be elopement risks.<br><br>The inservice covered the signs that potential elopement risk residents may exhibit. An elopement risk assessment was placed in each resident's clinical record and, a copy of the elopement risk inservice was signed by each employee and placed in their individual personnel file.<br><br>All new admissions will be assessed for elopement risks. No resident will be admitted without this assessment having been completed. All residents will be checked daily for any changes in their elopement potential by all nursing staff. This information will be put in the | |

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| | she alerted other staff members, and a search was begun of the facility and grounds. Resident B could not be found. Family and police were notified. Facility staff were dispatched in areas around the facility to search for resident B. Interviews with staff indicated he was last seen sometime between 2:00 P.M., and 2:30 P.M., in the outside area used for smoking. She indicated that later that day 2 staff members who were searching for Resident B observed him at a gas station near his home. The gas station was 6 miles walking distance from the facility. The staff members called the police, who came and took Resident B to a hospital for evaluation. He was returned to the facility at 12:30 A.M., on 6/23/2017.<br><br>During the interview above the SSD indicated no elopement risk assessment had been done for Resident B, either on admission or later, and no specific interventions related to elopement had been put in place. She also indicated that the facility did not typically assess residents for elopement risk unless there was a "red flag" such as a previous elopement attempt. The SSD indicated that CNA 1 had been interviewed after it was determined Resident B was missing, but could provide no helpful information, and apparently did not note Resident B | | elopement risk book.<br><br>The Social Services Director will monitor this elopement risk book on a daily basis for the first 2 weeks, then weekly thereafter on a continuous basis. The QA Committee will meet quarterly to assess all resident's potential elopement risks, to evaluate the elopement risk book, and to make any needed changes to the current policy and procedure. This will be an ongoing process for the QA Committee.<br><br>This plan of correction was completed at 7:30pm on July 3, 2017. | |

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| | was missing. The SSD indicated "Her focus was on the smokers." CNA 1 was unavailable to interview.<br><br>On 6/30/2017 at 4:30 P.M., the Director of Nursing (D.O.N.) indicated that following the facility investigation, they believed Resident B had exited the facility grounds by forcing open a locked chain link gate between the outside smoking area and the facility parking lot. She was unable to state if the gate had been found open or not.<br><br>Documentation in Resident B's record obtained from his previous facility at the time of his admission to the current facility and available to the facility for review and evaluation included: Report of Neuropsychological Testing dated 3/28/17: "... Staff also related that (Resident B) presents an 'elopement risk' as he has left the facility without leave in the past, including at least one incident of having walked alone to his (family member's) residence toward downtown Indianapolis...'in the middle of the night.' Resident now wears a Wanderguard (an electronic device which sets off a warning signal when the wearer approaches an exit) to indicate proximity to exits."<br><br>Comprehensive Psychiatric Evaluation | | | |

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| | dated 4/25/17: "This is a (description of Resident B) who has been admitted for delusions, agitation, and bizarre behaviors...with a history of dementia. He apparently, on a recent occasion...became agitated...and exited the building making it out to the parking lot...he also became very agitated and confrontational with staff...he has been pacing and restless..."<br><br>Medical History and Physical dated 4/25/17: "(Description of Resident B)...who was evaluated at (his previous facility) for recently having some delusions...He had increased anxiety since this and a significant amount of exit seeking recently..."<br><br>An undated Risk For Elopement, believed to be from Resident B's admission to his previous facility on 12/22/16, indicated "yes" answers to the questions:<br><br>"1. Is resident physically able to leave the building on their own?<br><br>2. Is the resident cognitively impaired? If 1 and 2 are marked yes, proceed to questions 3-8.<br><br>3. Does the resident have impaired decision making skills.? | | | |

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| | If "Yes" is marked for #1 and 2 and any other (#3-8), consider a prevention plan of care for elopement."<br><br>The assessment included a hand written note "Wanderguard LLE (left lower extremity.)"<br><br>A Medication Review Report dated May 1, 2017 included the order "Check Wanderguard placement to L (left) ankle every shift. Order status: Active. Order date: 12/22/2016. Start date: 12/22/2016."<br><br>The record of Resident B was reviewed on 6/30/17 at 10:00 A.M. Diagnoses included, but were not limited to, a history of traumatic brain injury, amnesia, mood disorder (unspecified), personality disorder (unspecified), anxiety disorder, delusions, ADHD (attention deficit hyperactivity disorder), gastro-esophageal reflux disease, and encephalopathy (damage to the brain.)<br><br>Resident B was interviewed twice on 6/30/17. At 9:45 A.M., he indicated he did leave the facility, and would continue to try to do so. He indicated "I'm p.... off about being here. People have been lying to me my whole life." At 11:10 A.M., he indicated "I just walked out the gate. It was wide open. I didn't have to push it | | | |

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| | open. It was already open." He did not seem able to recall anything about his stay in the previous facility.<br><br>A Social Services Progress Note dated 5/24/17, entered by the SSD, indicated "...Alert to name, disoriented to time and place...isn't a good historian, doesn't seem to recall any of the events that brought him here...Res (resident) constantly ambulates about the halls most of the day...Possible elopement risk..."<br><br>A Social Services Progress Note dated 6/22/17 at 3:00 P.M., entered by the SSD, indicated " This writer was setting up for evening activity when it was discovered that (Resident B) missing (sic). A search of the facility grounds was conducted and we were unable to locate res (resident)...Family members and police were called...Staff members were sent in each direction in attempt to locate res...Social Service Dir (Director) conducted interviews (symbol for "with") staff et (and) resid (residents) and it was determined he was last seen between 2:00-2:30 in the patio area with residents who go out to smoke. (Resident B's family member) stated he has a history of elopement and usually returns to the family home..."<br><br>A Nurse's Note dated 6/22/17 at 3:15 | | | |

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| | P.M., entered by the D.O.N., indicated "...called by Social services that they were unable to find a resident. Went immediately to the facility and made sure that family, Police and MD were notified...Staff continued with the search...(I) reached the administrator and he came immediately to the facility. The resident was found unharmed close to (family member's) home...Resident was taken to the hospital for observation..."<br><br>Resident B's record did not contain any elopement risk assessment, interventions, or cautions, or care plans related to elopement risk.<br><br>An observation was done on 7/01/17 beginning at 9:00 A.M. All residents were accounted for. There were no residents outside in the patio smoking area. The chain link gate to the parking lot was secured. An attempt was made to push open the gate as the D.O.N., had suggested Resident B might have done. A significant force was applied and the gate would not open.<br><br>The D.O.N. and the SSD were in the facility. They indicated Resident B had been sent out on the afternoon of 6/30/17 for inpatient psychiatric evaluation and would not be returning to the facility. | | | |

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| | On 7/03/17 at 1:30 P.M., an observation of the chain link gate to the parking lot was done with the Maintenance Supervisor. He indicated that on 6/22/17, after it was discovered Resident B was missing, he received a call from facility staff who indicated the gate had been found open, and they were unable to properly latch it. He indicated he came to the facility, and found that the latch on the gate was loose, allowing it to turn on the gate post, and the gate to be pushed open, even though it was locked with a padlock. He indicated how he had repositioned the latch and securely tightened it, making it impossible to push open. The gate was tested, and it could not be pushed open.<br><br>An undated facility policy titled "Resident Assessment-Licensed Nurse Procedure" received from the SSD on 7/03/17 at 10:20 A.M., indicated: "Purpose: To gather comprehensive information as a basis for identifying resident problems/needs and developing or revising an individual plan of care." Sections under the heading "Table of Focused Nursing Assessments" included: "Upon Admission: Nurse's Assessment Record... Assessments to be completed within the first fourteen days in conjunction with the MDS process...Other Assessment | | | |

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| | Monitoring..."<br><br>The above noted procedure did not contain any reference to elopement risk assessment.<br><br>The Immediate Jeopardy that began on 06/22/17 was removed on 07/03/15 at 1:00 P.M., when the facility provided documentation of development of revised policies and procedures related to elopement risk assessment, an updated elopement risk form had been created, all current residents had been assessed for elopement risk, re-education of staff members on elopement prevention had begun, and all potential exits from the facility had been checked and secured. The noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all employees had not been inserviced.<br><br>This Federal tag relates to Complaint IN00233570.<br><br>3.1-45(a)(2) | | | |