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	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT HOBART	1420 ST MARYS CIRCLE HOBART, IN 46342

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00434733. Complaint IN00434733 -State deficiencies related to the allegations are cited at R0052, R216, R240 and R349. Survey dates: May 21 and 22, 2024 Facility number: 002627 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/24/24.	R 0000		
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: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, record review, and interview, the facility failed to ensure a resident was free from neglect related to not implementing effective supervision of a resident with known exit-seeking behaviors to maintain the resident's safety resulting in fractures from an elopement from the facility through a second floor window on the memory care unit, for 1 of 3 residents reviewed for accidents. (Resident B) The facility also failed to ensure staff responded timely and	R 0052	The corrective action taken that will be accomplished for the residents will be for the ED/DON to conduct mandatory training sessions for all staff members on recognizing and responding to exit alarms, including the WanderGuard system. Emphasize the importance of timely and	07/23/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Ciak	Regional Director of Operations	06/11/2024

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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	appropriately to an alarm that indicated a resident with a Wandergaurd (a device worn that will trigger an alarm when exiting building) may have exited the building during a random observation. Findings include: 1. An Indiana Department of Health (IDOH) Reportable Incident, dated 5/16/24, indicated at 9:45 a.m. the resident was observed on the south side of the building on the ground. The fire department was present. The resident had removed a window from another resident's room on the second floor of the memory care unit and "lowered self to the ground." The resident was taken to the emergency room for evaluation and treatment. The resident was found to have a transverse C7 fracture, an L3 vertebral body (bones in the spinal column) fracture and multiple abrasions on his right arm. He remained in the hospital. Resident B's record was reviewed on 5/21/24 at 1:40 p.m. The resident was admitted to the facility on 4/18/24. Diagnoses included, but were not limited to, unspecified dementia, anxiety disorder, major depressive disorder and chronic atrial fibrillation. The resident resided on the first floor, which was unlocked and not the locked memory care unit. A Cognitive Assessment, completed on 4/18/24, indicated the resident had severe cognitive impairment. A Wandering Assessment, completed on 4/18/24, indicated the resident was a high risk for wandering due to being disoriented to time and place, dementia, newly admitted, and a history of wandering.		appropriate responses to alarms. All staff will be educated by 7/23/24. Then education will continue monthly for all employees for the next 6 months. All residents that have exhibited exit-seeking behaviors have the potential to be affected. To ensure this deficient practice doesn't reoccur, the DON/designee to conduct thorough assessments for all residents with a history of exit-seeking behaviors. Develop individualized care plans that include specific interventions to mitigate elopement risks. Residents observed seeking an exit, they will be given a wandering risk assessment immediately, then monthly X3, then quarterly on-going thereafter.	

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	A Health Status Note, dated 4/27/24, indicated around lunchtime, the Wandergaurd alarm was heard and the resident was observed attempting to exit the facility through the front door. Staff was able to redirect him back inside. There were no previous progress notes that indicated when or why the Wandergaurd was initiated. An IDOH Reportable Incident, dated 5/11/24, indicated at 3:45 p.m. the front entry door alarm was sounding and the resident was observed outside the facility under the awning near the facility bus. Staff was able to redirect the resident back inside. A Behavior Note, dated 5/12/24, indicated around 1:30 p.m., the resident was on the memory care unit in the elevator attempting to leave. The elevator required a code to operate from memory care. The resident would not get out of the elevator and became combative and agitated. He was eventually redirected out of the elevator and continued to exit seek from the unit. A Hospital Note, dated 5/16/24, indicated the resident presented with multiple skin abrasions and a CT scan (computerized tomography - a medical imaging procedure that uses X-rays and computers to create detailed images of the inside of the body) showed C7 & L3 vertebral (spinal) fractures. The plan was admission for spine surgery and a pulmonary (lung) consult. During an interview with the Executive Director (ED) on 5/22/24 at 9:04 a.m., she indicated the Wandergaurd had been initiated as a precaution because the resident had been observed wandering often. The family provided a paid caregiver for the first two weeks while the resident			

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	acclimated to the facility. The family had been against placing the resident on the memory care unit, but after the elopement on 5/11/24, he began going there for day programming to keep him busy. There was no longer a bed available on memory care, so referrals had been sent to other facilities due to his ongoing exit seeking. Staff statements from the 5/16/24 facility investigation were reviewed and indicated the resident had been taken upstairs to memory care and sat down in the common area around 6:30 a.m. He was observed wandering in the hall around 8:40 a.m. and observed seated in the dining room around 8:45-9:00 a.m. During an interview with CNA 2 on 5/22/24 at 1:45 p.m., she indicated she was working on memory care on 5/16/24 and had last seen the resident around 8:40 a.m. walking in the hall. She was getting other residents up that morning. After breakfast, she and other staff noticed Resident B was not in the dining room. They notified the QMA (qualified medication aide), who immediately called a Code Pink (missing resident alert). They began going room to room looking for the resident. The CNA entered room 405 and saw the window had been removed from the frame and was leaning against the bed. She ran to the window and looked down, there was a shoe, but no resident. She ran and told the QMA. The ED indicated the resident had exited the window on the west side of the building and had made his way to the south side of the building. An unknown person in the apartments next to the facility had seen the resident on the ground and called 911. As staff were responding to the Code Pink and circling the building outside, the fire department had arrived and found the resident.			

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	The window in room 405 was observed on 5/21/24 at 2:20 p.m. with the ED and the Maintenance Director. The windows opened by sliding side to side. There was a metal stop that allowed the window to only open 6-7 inches. The Maintenance Director demonstrated that by holding the window on both sides and lifting up, the window was able to be tilted inwards and removed. All windows in the building were the same. The ED indicated the doors on memory care would automatically lock from the outside when closed, but the resident in room 405 had unlocked hers so it could be opened without a key. 2. On 5/22/24 at 8:38 a.m., the Wandergaurd alarm by the front door was activated. At 8:39 a.m., Resident E was observed sitting in a chair outside near the entrance door. The Activity Director (AD) was observed entering the door and commented the resident was sitting outside. There were no other staff around and the alarm continued to sound. During an interview with the resident at 8:40 a.m., she indicated she did not have a Wandergaurd on. She indicated she used to wear one but it was removed so she could sit outside. There was not a Wandergaurd observed on her wrist, ankle or walker. Inside the facility, the alarm continued to sound. Dietary staff was observed serving a beverage to a resident in the dining room. Resident E returned inside at 8:44 a.m. and sat down in the lobby area. The AD was in the kitchenette near the entrance. A visitor entered and asked her what that alarm was. She indicated it was the Wandergaurd alarm, but she didn't know why it was going off. At 8:51 a.m. Housekeeper 1 entered the area and turned			

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	the alarm off without checking outside. During an interview with the ED at 8:55 a.m., she indicated one resident had a Wandergaurd and she was currently in her room. She didn't know why the alarm was set off, but staff should have responded appropriately, and she understood the concern. The policy, "Missing Resident/ Elopement Policy and Procedure", indicated, "...a. It is the responsibility of all staff, regardless of the department they work in, to respond to activated door alarms and to return residents to their units if required: i. If a door alarm sounds and staff do not see who activated the door alarm the staff member will open the exit door and look outside to see if a resident has exited the Community...ii. If staff are not able to determine who/ what activated the alarm a resident head count will be conducted to verify if a resident is missing...." This citation relates to Complaint IN00434733.			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in			

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	writing and kept in the facility. Based on record review and interview, the facility failed to timely update a resident's Service Plan with interventions related to exit seeking and wandering for 1 of 3 residents reviewed for accidents. (Resident B) Finding includes: Resident B's record was reviewed on 5/21/24 at 1:40 p.m. The resident was admitted to the facility on 4/18/24. Diagnoses included, but were not limited to, unspecified dementia, anxiety disorder, major depressive disorder and chronic atrial fibrillation. The resident resided on the first floor, which was unlocked. A Cognitive Assessment, completed on 4/18/24, indicated the resident had severe cognitive impairment. A Wandering Assessment, completed on 4/18/24, indicated the resident was a high risk for wandering due to being disoriented to time and place, dementia, newly admitted, and a history of wandering. A Health Status Note, dated 4/27/24, indicated around lunchtime, the Wandergaurd alarm was heard and the resident was observed attempting to exit the facility through the front door. Staff was able to redirect him back inside. There were no previous progress notes that indicated when or why the Wandergaurd was initiated. A Reportable Incident, dated 5/11/24, indicated at 3:45 p.m. the front entry door alarm was sounding and the resident was observed outside the facility under the awning near the facility bus. Staff was able to redirect the resident back inside.	R 0216	The corrective action will be DON/Designee will update service plan promptly to include specific interventions and strategies to manage exit seeking and wandering behaviors as soon as they are observed. After the initial update occurs, it will be updated immediately, for each change of condition, and quarterly on an on-going basis. All residents with exit-seeking behavior have the potential to be affected. ED/DON/Designee will be conducting training sessions for all staff members to ensure they understand the importance of recognizing signs of exit seeking and wandering. All staff will be educated by 7/23/24, then monthly X 6 months. Nursing staff will be re-educated on updated service plans when wandering is observed by 7/23/24. This training would also cover how to implement and document interventions effectively. This will be monitored by auditing service plans weekly x 4 weeks, bi-weekly x4, monthly x3, and quarterly ongoing. This will be monitored by DON/designee. **Regular Review and Monitoring**: Implementing a system for more frequent and systematic reviews of all residents' Service Plans, particularly those with a history or risk of wandering and exit seeking.	07/23/2024

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	The Initial Service Plan, dated 4/18/24, did not address exit seeking or wandering. The Cognition plan indicated the resident had mild to moderate disorientation or difficulty recalling/ retaining information and needed cueing. The Service Plan was not updated until 5/11/24. Resident B was an elopement risk as evidenced by actively exit seeking. Interventions included: to attempt to engage in pleasant, meaningful activities during episodes of constant wandering, by directing him to memory care unit to participate, and Wandergaurd device to left ankle. During an interview with the Executive Director on 5/22/24 at 9:04 a.m., she indicated the Wandergaurd had been initiated as a precaution because the resident had been observed wandering often. She indicated she did not update the Service Plan until after the actual elopement on 5/11/24 and probably should have updated it earlier. The policy, "Missing Resident/ Elopement Policy and Procedure", indicated, "...B. Service Plan Development 1. The Administrator or designee will develop/ revise the service plan immediately upon determination that a resident is at risk for elopement...." This citation relates to Complaint IN00434733.		This will occur monthly at QA x6 months. ED/DON will be responsible.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to ensure a resident was free from accidents	R 0240	The corrective action plan to ensure reoccurrence doesn't	07/23/2024

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	and hazards related to the improper transfer of a resident which resulted in a fall, for 1 of 3 residents reviewed for accidents. (Resident C) Finding includes: Record review for Resident C was completed on 5/22/24 at 10:14 a.m. Diagnoses included, but were not limited to dementia and anxiety. The Level of Care Assessment, Individualized Service Plan, dated 3/18/24, indicated the resident was confused and resided on the memory care unit. The resident required full assistance with ADLs (activities of daily living). The resident was independent with mobility but required prompting and reminders. A Progress Note, dated 4/25/24 at 8:00 p.m., indicated the resident had fallen around 6:20 p.m. and was sent to the emergency room (ER). An Indiana Department of Health Reportable Incident was completed on 4/26/24. The incident indicated: - Description added: 4/26/24 nurse on duty called into room per CNA with resident observed laying on left side with bleeding observed from left side of head. - Type of injury: laceration to left side of head - Immediate Action Taken: 911 called and resident sent to ER for evaluation and treatment - Preventative Measures Taken: Staff in-serviced on routine checks and proper transferring. - Follow up added: Resident returned with 4 staples to left side of head. Will monitor and notify MD with any significant changes. During an interview on 5/22/24 at 10:40 a.m., the Executive Director (ED) indicated she was		happen is; DON or Designee will provide an in-service to all nursing staff about the proper way of transferring a resident. All residents that are at risk for a fall have the potential to be affected by this deficient practice. The corrective action plan will be education of nursing staff by 7/23/24, then monthly X 6 months. To ensure education was followed, DON or designee will conduct observations on resident transfers on varying shifts 3 times/week X 4 weeks and then monthly x 5 months. To prevent potential recurrence, all falls will be reviewed by ED/DON daily. Additionally, falls will be reviewed monthly at QA. DON or designee will be responsible.	

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	informed the resident had a fall and was sent to the ER. The resident had a camera in her room. She reviewed the video footage and observed the resident standing in the room with CNA 1. The resident had 2 floor mats that were folded together and on top of each other next to the resident's bed. The CNA assisted the resident to sit down on the folded up mats while she was making the resident's bed. The resident fell sideways off of the mats and onto the floor. The ED indicated the CNA should have had the resident sit on the bed or in a chair and not on the mats. The CNA had performed an improper transfer with the resident and the fall could have been prevented. This citation relates to Complaint IN00434733.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete related to lack of an assessment or physician's order for a Wandergaurd for 1 of 3 residents reviewed for accidents. (Resident B) Resident B's record was reviewed on 5/21/24 at 1:40 p.m. The resident was admitted to the facility on 4/18/24. Diagnoses included, but were not limited to, unspecified dementia, anxiety disorder, major depressive disorder and chronic atrial	R 0349	The corrective action plan will be DON or designee will educate all nurses on when to complete a wandering risk assessment, when to initiate an elopement alert device, and how to properly obtain an order. DON/designee will complete an audit for all residents that are currently wearing a Wanderguard.	07/23/2024

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	fibrillation. The resident resided on the first floor, which was unlocked. A Cognitive Assessment, completed on 4/18/24, indicated the resident had severe cognitive impairment. A Wandering Assessment, completed on 4/18/24, indicated the resident was a high risk for wandering due to being disoriented to time and place, dementia, newly admitted and a history of wandering. A Health Status Note, dated 4/27/24, indicated around lunchtime, the Wandergaurd alarm was heard and the resident was observed attempting to exit the facility through the front door. Staff was able to redirect him back inside. There were no previous progress notes that indicated when or why the Wandergaurd was initiated. There was no assessment or physician's order for a Wandergaurd. During an interview with QMA 1 on 5/22/24 at 11:05 a.m., she indicated the resident wore a Wandergaurd and she was aware of at least two attempts to exit the building, but was unable to recall the dates. The Wandergaurd was applied after the first exit attempt. During an interview with the Executive Director (ED) on 5/22/24 at 9:04 a.m., she indicated the Wandergaurd had been initiated as a precaution because the resident had been observed wandering often. She had no additional information why there was not a physician's order. This citation relates to Complaint IN00434733.		All residents that have a WanderGuard have the potential to be affected by this deficient practice. To prevent this recurrence from happening again, all residents with a Dementia diagnosis that do not reside on memory care will have a wandering risk assessment completed at admission, if they exhibit exit seeking behaviors, and quarterly on-going. DON/designee will be responsible.	