STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIARCLIFF HEALTH & REHABILITATION CENTER	**5024 WESTERN AVENUE SOUTH BEND, IN 46619**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate supervision and a safe, secure environment to prevent elopement for 1 of 1 resident reviewed for elopement (Resident B). The facility failed to ensure the resident's window was secure, failed to complete window safety checks, and failed to complete monitoring of the resident every 15 minutes as care planned, leaving the facility unaware Resident B had exited the facility unsupervised for 45 minutes until he was found 1.3 miles away on a busy street. The immediate jeopardy began on 8/04/2020 when Resident B exited the facility through his window in the memory care unit, resulting in Resident B being found 1.3 miles from the facility, on a busy street. The Facility Administrator and the Director of Clinical Operations were notified of the immediate jeopardy on 9/01/2020 at 4:57 P.M. The immediate jeopardy was removed on 9/3/2020, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding includes: A clinical record review was conducted on 8/31/2020 at 11:35 A.M., and indicated Resident B was admitted on [DATE]. His [DIAGNOSES REDACTED]. A hospital discharge document, prior to admission of Resident B to the facility, indicated Resident B was medicated in the hospital due to .agitated and uncontrollable . and there was a recommendation for admission to .a monitored bed A nurse's note, dated 6/18/2020, indicated Resident B had a Wanderguard (a bracelet that has a sensor inside it to alert elopement attempts) on his left ankle and was moved to a different room closer to the nurses' station on the memory unit due to an elopement risk. An incident report, dated 6/19/2020 at 2:01 P.M., indicated the resident was seen through the therapy gym window climbing out of his window after breaking the set screw that only allows the windows to partially open. The resident resided on the memory care unit. Preventative measure taken was placing resident on 1:1 staff supervision. Follow up indicated, .visible through the therapy windows, resident was seen by another resident climbing out of their window, and remained there while putting the screen back in. Other resident notified the Physical Therapy assistant, who went outside, and walked the resident back into the facility. The resident stated that 'He had to get to work before dark.' The resident had broken the set screw which limits the space the window is able to be open. The screw was replaced, and other windows audited to ensure that the screw was in place, and functioning properly. Resident at this time was also placed on 1:1 supervision until 6/22/2020. Physician and family were notified about incident. On 6/22/2020, resident was discharged to Neuro Psych Hospital for evaluation and treatment A window check audit was made available for 6/21/2020, by the Administrator who indicated this was the only documented audit of the windows available. A nurse's note, dated 6/19/2020 at 2:29 P.M., indicated .Wandering, in hallway, requesting cigarettes. Multiple attempts to open secured doors only stopping behavior after alarms rang and attempted to elope out of his bedroom window by removing window screen. Unable to redirect from above behavior. Resident makes no eye contact when spoken to and repeats statement over and over 'how can I get out of here' A nurse's note, dated 6/19/2020 at 4:30 P.M., indicated .Resident remains on 1:1 on the unit d/t (due to) his multiple attempts to leave the unit (not easy to re-direct) currently showing no s/s (signs or symptoms) of agitation resident continues to pace throughout the unit. Family is aware of his behavior (climbing out of his window in his room as this is resulting in an emergency detention) he will remain on the 1:1 until he is transferred for further evaluation at a (local) medical behavior hospital sometime tomorrow A psychosocial note, dated 6/19/2020 at 4:51 P.M., indicated Social Service department made a referral to a neuro psych hospital; however, there were no available beds. A nurse's note, dated 6/20/2020, indicated Resident B continued on 1:1 supervision. A nurse's note, dated 6/20/2020, indicated .Observed up out of chair pushing on door, pacing at times, able to redirect back to seat A nurse's note, dated 6/21/2020, indicated 1:1 supervision continued. A nurse's note, dated 6/21/2020 at 4:00 P.M., indicated .Resident continues on 1:1 monitoring, in dining room for dinner, head on table, no s/s of distress or discomfort, oriented to person, able arouse easily. Up now pacing in dining room, looking out door, pushing on door, Wanderguard activated alarm A nurse's note, dated 6/21/2020 at 6:07 P.M., indicated .up in hallway pacing, says 'I need to get out, gotta get my drink and smoke.' 'Where is the bathroom.' Resident assisted to restroom, toileted self. Encouraged to rest, unsuccessful, continues to pace in hallway mumbling to self. Will continue to monitor 1:1. Reported off to next shift plans for possible discharge tomorrow 6/22/2020 for psychiatric treatment A physician progress notes [REDACTED].M., indicated .He removed his (wanderguard) ankle bracelet earlier today and does not seem to be able to explain the reasoning to the nurse. Pt (patient) is aphasic(speaking unrecognizable words) at times. He answers questions appropriately at times and then rambles on with word salad(speaking in random words or phases) at times. Nurse reported pt is exit seeking and has attempted to open alarmed door at times. Order was given to send to Neuro psych hospital for further evaluation and treatments. Neuro psych is still waiting for an available bed for pt A nurse's note, dated 6/23/2020, indicated Resident B was in the hospital. A nurse's note, dated 7/15/2020, indicated Resident B was admitted back to the facility. A behavior note, dated 7/20/2020 at 4:30 P.M., indicated .Upon making rounds by QMA (qualified medication aide) it was discovered that resident had removed security bolt from his rt (right) lower window ledge (Resident B's room number) and had removed the bottom screen. Resident was observed inside the room standing by the window and was never outside. Immediate 1:1 staff coverage for attempted elopement ordered until further notice A physician progress notes [REDACTED].Patient is seen today for follow up due to his recent neuro psych hospitalization . He was sent out to neuro psych hospital on June 23, 2020 for increased behavior that included yelling and throwing things in his room as well as trying to climb we know which (sic) comments that he has to go to work before it gets dark, he was also wandering 2 different rooms (sic), with increased confusion. At that time current psychiatric symptoms include and (sic) verbal aggression, impulsivity, delusions and [MEDICAL CONDITION]. He returned to (the facility) on 7/15. He is not in any acute distress at this time. However, he still seems confused and impulsive walking about the unit. No reports of fever, chills, or dyspnea noted. A referral order written for neurology consultation due to increased behaviors and history of recent brain lesion A MDS (minimum data set) Medicare 5 day assessment, dated 7/22/2020, indicated Resident B had severe cognitive impairment. A nurse's note, dated 7/22/2020 at 3:38 P.M., indicated Resident B was under 1:1 supervision and was wandering up and down unit. A nurse's note, dated 7/24/2020 at 2:24 P.M., indicated .1:1 staffing dcd (discontinued), and q (every) 15 min (minute) assessments initiated. No further evidence of attempts to elope thru window or elsewhere. Speech loud/garbled at time but is able to make needs known on most occasion (sic), Gait even/steady w/o (without) evidence of weakness or falls A behavior monitoring note, dated 7/26/2020 at 2:38 P.M., indicated .resident in his room seen by this nurse attempting to force open the window. Verbally redirected, unable to comprehend initially due to confusion. Resident eventually settled down on a chair in his room A physician progress notes [REDACTED].Patient is seen today for increased behavior follow up. He is observed walking about the unit. He has taken his bed apart but has not been aggressive today A nurse's note, dated 7/28/2020 at 2:45 P.M., indicated Resident B .Frequently requesting to leave building with staff to go to the bank. Able to redirect after several

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) attempts A physician note, dated 8/3/2020, indicated .Patient is seen today for a follow up visit. He was reported to be exit seeking but not boisterous. He is observed looking out the window in his room. He appears to be calm at the moment but staff reports moments of him wanting to go outside when staff is leaving, saying that he needs to go the bank or such thoughts. Pt is very confused with obvious impaired judgement statements Documentation was lacking to indicate increased supervision was provided even though the resident attempted to exit the facility since 1:1 supervision was discontinued on 7/24/20. An incident report, dated 8/4/2020, indicated a .Brief Description of incident: resident was found to be outside of the facility, found by a staff member that was off duty. Resident was last seen in the secured dementia unit at 8:45 P.M., and noticed at 9:30pm. Resident was returned to the facility safely. Preventive Measures taken: resident was immediately placed on 1:1 supervision. Follow up: Resident was last seen at 8:45 pm on 8/4/2020 by the nursing station. At 9:30 pm approximately, another staff member (off work and not scheduled) was driving a few blocks away from the facility and noticed the resident. Resident went into the employee's car, and returned to the facility. Resident was immediately assessed with [REDACTED]. When interviewed by staff, resident stated he 'had enough of this place.' Upon interview with the family, they stated that he was out at night, and also would come and go, sometimes being gone for 2-3 days without anyone knowing his whereabouts. Upon investigation, resident had jarred set screw again, causing it to break off. Windows had recently had all new screws installed, also rods placed in casing so the windows could not be moved up and down, then out, for cleaning purposes. (Physician's name) Medical Director, and (nurse practitioner's name), NP also assessed the situation, and agree the facility is not the proper placement for this resident. Resident also has a physician appointment on 8/11/2020 with (a physician's name), neurologist for assessment and treatment of [REDACTED]. Prior to this, family states that his mood/cognition was not altered. Resident sent out to Neuro hospital on [DATE], evening time. Facility will work with hospital for future placement, and assist as needed A nurse's note, dated 8/5/2020 at 7:44 A.M., indicated .This nurse was informed by 3-11 supervisor that resident was seen walking near a (four lane highway). This nurse drove to the area, did not see resident. Called 3-11 supervisor, was informed that resident was in an employee's vehicle at (local restaurant name). Drove my vehicle back to the facility, parked, and ran next door to the restaurant. Seen resident in employee's vehicle. As vehicle doors were unlocked, this nurse entered in to the back seat. Verbalized with resident, then returned to facility with resident driven by employee. Resident refused to leave from the vehicle at the facility, various staff members spoke with resident. This nurse returned to unit as resident was in the company of other staff members A review of Resident B's behavior monitoring documentation showed no documented behaviors for 6/19/2020, 7/20/2020 or 8/4/2020, for elopement attempts. A care plan, dated 7/24/2020, indicated Resident B was to have every 15 minute checks completed .for safety/elopement risk until further noticed (sic) A form, titled Safety Checks, dated 8/4/2020, indicated Resident B was in the facility between 8:45 P.M. and 9:30 P.M. During an interview, on 8/31/2020 at 2:34 P.M., the Administrator indicated the facility did not know which window Resident B got out of, on 8/4/2020. During an interview, on 8/31/2020 at 2:48 P.M., the facility maintenance employee indicated there was no available documentation related to window safety checks being completed. On 8/31/2020 at 2:48 P.M., a window in the common area of the memory care unit was observed to have a plastic piece of the lower window sill sticking up the length of the palm of a hand and had the right safety screw removed from the window sill. At this time, the maintenance employee indicated he was unaware of this window being broken. During an interview, on 9/1/2020 at 11:10 A.M., the Social Service Director indicated there were no available assessments to indicate Resident B was safe to be removed from 1:1 supervision. She indicated the interdisciplinary team met and decided to remove Resident B's 1:1 supervision, due to him having a lack of behaviors for four days and staffing being a concern. During an interview, on 9/1/2020 at 4:30 P.M., Nurse 3 indicated she had made a mistake by filling in empty holes on the 8/4/2020 safety check documentation and indicated Resident B was not in the facility from 8:45 P.M. thru 9:30 P.M. A care plan, dated 6/19/2020, indicated Resident B was an elopement risk/wanderer with history of attempts to leave facility unattended, impaired safety awareness, cognitive decline. Resident wanders aimlessly. The care plan was dated as last revised on 7/21/2020. Interventions included: Complete head to toe assessment (8/4/20), Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: (blank) (6/19/20), Monitor location as needed. Document wandering behavior and attempted diversional interventions in behavior log (6/19/20 then revised on 7/21/20). Notify MD, POA (power of attorney), Administrator (8/4/20), Provide structured activities: toileting, walking inside and outside, reorientation strategies including sings, pictures and memory boxes (6/19/20). Q (every) 15 minute check for safety/elopement risk until further notice (7/24/20). Resident to be in staff line of sight unless sleeping in bed (8/4/20). Resident B's care plan lacked interventions to address him attempting to open windows or the facility ensuring the windows were secured. A policy was provided by the Clinical Operations Manager, on 9/2/2020 at 10:40 A.M., titled Wandering and Elopements, dated March 2019, and indicated this was the policy currently used by the facility. The policy indicated .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents The immediate jeopardy that began on 8/4/2020 was removed on 9/3/2020 when the facility reviewed and implemented safety checks for windows in the memory care unit, in-serviced staff related to individualized elopement care planning and implemented a monitoring system for the 15 minute checks and 1:1 supervision, but noncompliance remained at the lower scope and severity of isolated, no harm with potential for more than minimal harm that is not immediate jeopardy because of the need for continued education and monitoring. This Federal tag relates to complaints IN 926 and IN 423. 3.1-45(a)(2)