STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155076	A. BUILDING _____ B. WING _____	**06/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-BROOKVIEW	**7145 E 21ST STREET INDIANAPOLIS, IN 46219**

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 ensure adequate supervision and interventions were provided to prevent a cognitively impaired resident, who was assessed by the facility as an elopement risk, from exiting the facility unsupervised, for 1 of 1 resident reviewed for elopement (Resident B). The resident was able to exit the Alzheimer's Care Unit (ACU) and a facility exit door without the knowledge of staff. When the exit door alarmed, a staff member reset the alarm without checking outside the door for any resident. The resident was missing for more than 17 hours when found at a store 7 miles away and returned to the facility after being notified by local police. The Immediate Jeopardy began on June 13, 2020, when a cognitively impaired resident with dementia exited the Alzheimer's Care Unit and the facility unsupervised into a potentially dangerous area, including a four-lane moderately busy road and bus stop, and was missing for approximately 17 hours when he was found 7 miles from the facility. A staff member turned off the exit door alarm, approximately 30 seconds after Resident B exited the facility, but did not attempt to go outside and examine the perimeter to see what could have set off the alarm to the exit door. The Area Vice President and Executive Director (ED) were notified of the Immediate Jeopardy on 6/14/20 at 6:27 p.m. The Immediate Jeopardy was removed on 6/15/20, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The clinical record for Resident B was reviewed on 6/14/20 at 3:39 p.m. The [DIAGNOSES REDACTED]. A Quarterly Interdisciplinary Resident Review, dated 1/30/20, indicated Resident B was cognitively impaired with impaired decision making skills that put him at risk for elopement. A care plan, revised 2/11/20, indicated the following, .I (Resident B) am at risk for elopement believing I need to get home. 4/25/20-Recently I have not been actively trying to leave and my roam alert has been discontinued .Interventions .Find something on the unit I would like to do to divert my attention from the door .Walk with me through the unit The resident resided on the Alzheimer's Care Unit which required a code to exit the door. A Quarterly Minimum Data Set (MDS) assessment, dated 4/7/20, noted a Brief Interview for Mental Status (BIMS) score of 8 that was indicative of moderate cognitive impairment. Resident B needed supervision with one staff person for transfers, walking, locomotion and eating along with extensive assistance with one staff person for toileting and personal hygiene. A news article, dated 6/14/20, indicated Resident B was missing from the facility since midnight. An incident report from the Indiana State Department of Health Survey Report System, dated 6/14/20 at 1:10 a.m., indicated the following, .(Name of Resident B) .Brief Description of Incident .On 6/14/20 at 0110 (1:10 a.m.), a Nurse Manager was notified by phone from a night shift nurse that while conducting a bed check for night time care, (Resident B's) whereabouts were unknown. The Nurse stated the facility had conducted a full internal search and the Nurse Manager, instructed to complete a full external search of the facility property .During the search and investigation, the facility identified on the security system that (Resident B) exited the facility through a side entrance/exit door that is not used by staff or visitors .(Resident B) was identified at 1150 (11:50 a.m.) On 6/14/20 at 2:30 p.m., an observation was made of the camera footage from the evening of 6/13/20. At 6:13 p.m., on 6/13/20, Resident B was identified as standing at the exit door just outside of the ACU. Resident B was pushing towards that exit door until he was able to push it open, at 6:14 p.m. Resident B proceeded to walk down the ramp while grasping the railing with his left hand and holding onto a shopping bag with his right hand. When Resident B exited from the camera, 30 seconds later, a staff member is identified, by the ED, as clearing the alarm from that exit door. There was no staff member observed exiting the building to determine what caused the door alarm to activate or check the perimeter. A form titled Daily Staffing Schedule, dated 6/13/20, indicated Registered Nurse (RN) 4 was working on the ACU with Certified Nurse Aide (CNA) 6 and CNA 8 on evening shift. An interview documented with CNA 8, dated 6/14/20, indicated the following, .I (CNA 8) didn't see him (Resident B) walking around like he usually does, but I saw him in the bed at about 2:30 p.m. The other aid (sic) was caring for those residents A written statement by RN 4, dated 6/14/20, indicated the following, .I (RN 4) gave (name of Resident B) his PM (evening) meds (medications) @ (at) 6pm. He was walking down the hall holding a Christmas shopping bag @ (at) this time. I was doing a bed check @ (at) 10:45 p.m. when I noticed (name of Resident B) was not in his room. I went to the TV room where he sits sometimes until he gets sleepy. When I didn't see him I asked the QMA (Qualified Medication Aide) if she had seen him and she said no. Then we started a room by room search and then expanded it to the rest of the building and around the outside of the building A written statement by QMA 10, dated 6/13/20, indicated the following, .came to ACU to work time about 10:45 p.m. doing charting on computer. (Name of RN 4) stated she should check on (name of Resident B). Walked with her (RN 4) but when we got to his (Resident B's) room he was nowhere to be found. Then started checking all rooms and bathrooms still couldn't find him (sic). We expanded our search to the other units and still couldn't locate him. I got flashlight started calling his name along creek (sic) and the woods on the back of property but couldn't locate resident Resident B was last seen by RN 4, on 6/13/20 at 6:00 p.m., for his evening medications. Resident B was realized to be missing 4 hours and 45 minutes later, on 6/13/20 at 10:45 p.m., during a bed check by RN 4 and QMA 10. A progress note, dated 6/14/20 at 11:45 a.m., indicated the following, .Notified by police that pt. (patient) has been found Another progress note, dated 6/14/20 at 1:03 p.m., indicated the following, .Head to toe assessment: Resident is alert and oriented to self and familiar faces. He is able to ambulate with a slow, steady gait. Breath sounds are clear. Bowel sounds present, resident had just eaten lunch. He was incontinent of bowel and bladder. He was showered. Overall, skin intact, lack of approx. (approximately) 2 x 2 blister on Left great toe and small 1x1 reddened areas to right 4th and 5th toe An interview conducted with the Director of Nursing (DON), on 6/14/20 at 4:17 p.m., indicated Resident B returned to the facility on [DATE] at 12:15 p.m. He was incontinent of bowel and bladder upon return to the facility. An interview conducted with the ED, on 6/14/20 at 2:10 p.m., indicated upon review of the camera footage it was determined Resident B exited the facility at 6:14 p.m. He was unsure how Resident B made it off of the ACU. Resident B was able to push the exit door, outside the ACU, until it disengaged and he opened the door to walk down the ramp towards the bus stop. Resident B's family indicated he loved riding the bus. An interview conducted with the ED, on 6/15/20 at 4:50 p.m., indicated when an exit door alarm sounds the expectations are for staff to go outside and check the perimeter to see if a resident is present. If a resident cannot be found then the staff are to conduct a head count to account for all residents in the facility. There was no policy for door alarms. A document titled Elopement Guideline, dated 1/28/19, indicated the following, .Elopement - When a resident leaves the premises or a safe area without authorization .and/or any necessary supervision to do so .Ongoing Review .All residents at risk of elopement are assessed quarterly and as needed .Door Alarms and Resident Protection Alarms .A specific system has been developed to notify staff that an external door has been opened in an area accessible to residents .Only the Executive Director/or designee may authorize disabling the alarm system and is responsible for the method of monitoring for resident's safety and resetting the alarm .Environmental Guidelines .The

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) LivingCenter will identify such environmental hazards such as entrances, stairwells, or exits that pose a foreseeable danger to residents who wander or have an exit seeking behavior. The LivingCenter will implement interventions to minimize these risks and hazards as appropriate .Documentation should include: .Entries that are time specific to reflect the responsiveness and timeliness of actions taken to locate and assess the resident This Federal tag relates to Complaint IN 236. 3.1-45(a)(2)