

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 09/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	<p>This visit was for the Investigation of Complaint IN00115532.</p> <p>Complaint IN00115532-Substantiated. State Residential finding related to the allegations is cited at R217.</p> <p>Survey date: 09/18/12</p> <p>Facility number: 004904 Provider number: 004904 AIM number: N/A</p> <p>Survey team: Sharon Whiteman, RN</p> <p>Census bed type: Residential: 34 Total: 34</p> <p>Census payor type: Other: 34 Total: 34</p> <p>Sample: 03</p> <p>This state residential finding is cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 21, 2012 by Bev Faulkner, RN</p>	R0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R0217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to implement interventions to prevent elopement for a resident assessed at high risk for elopement. This affected 1 of 3 residents reviewed for elopement in the sample of 3. (Resident A)</p>	R0217	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be	11/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Findings Include:</p> <p>During initial observation tour of the facility on 09/18/12 at 8:50 a.m., with the Director of Nursing (DON) present, the DON identified Resident A as being an elopement risk, as being independent with walking and transfers, and as being "very demented." The DON indicated Resident A's room was at the back of the facility upon admission, but the resident had been moved closer to the front of the facility after he eloped.</p> <p>A "Facility Incident Report Form" was provided by the Administrator on 09/18/12 at 9:30 a.m. The form indicated, "...Incident Date: 08/26/12 - Incident Time: 2:15 p.m....Brief Description of Incident: Door alarm sounded, CNA went to see who went out door, a family member of another resident told nurse that she thought [name of Resident A] got in a car with another residents (sic) family shortly before. Nurse called family member's phone and family said that [name of Resident A] had asked them for a ride to the gas station and they did not realize he was a resident and took him and dropped him off. [Name of Resident A] went out the door as the family went out. Staff immediately got into car and picked up [Resident A] across the street from the gas station. (The "street"</p>		<p>discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p> <p><b>Citation #1</b> <b>R 217</b> <b>410 IAC 16.2-5-2(e)(1-5)</b> <b>Evaluation- Deficiency</b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b> Resident A's service plan was reviewed and updated to include interventions to minimize the risk for elopement.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents found to demonstrate exit seeking and/ or behavioral disturbances had their service plans reviewed and updated to include interventions to minimize the risk for future occurrences.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	Resident A crossed was highway 50.)....Immediate Action Taken: Family (of Resident A) had came in about the time we went to pick [name of Resident A] up and stayed several hours with him. Fifteen minute checks were done into (sic) today. Medical Dr. notified. He [Resident A] is an Elopement Risk on task sheet and service plan so he is monitored closely. A urine dip stick was done to see if he might have a UTI. It was negative. Wanderguard bracelet will be placed on him. We will ask for an order for Home Health Psych nurse to have medication review and ongoing monitoring of behaviors. Door alarm will be placed on his door to alert us if he is out of his room so we can monitor him closer. Updated mini mental and elopement risk. Nurse completed head to toe assessment and there was no injuries. Family/Visitor was educated to not assist other residents from leaving the building. We have signs posted on doors to educate people of this also and we will move to draw more attention to them. Behavior plan put into place....Preventive measures taken: Elopement Risk on Task sheet and service plan. Wanderguard bracelet will be placed on him. Home Health psych nurse will do a medication review and ongoing evaluation of behaviors. Staff will be re inserviced about the policy on door alarms. Letter will be sent to		<b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The Residence Director and Wellness Director were re-educated to our policy and procedure regarding service level assessment completion. The Residence Director and/or Designee will be responsible for ensuring that service assessments are accurate and updated per our policy to ensure continued compliance with R217 410 IAC 16.2-5-2(e)(1-5) Evaluation.  <b>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Residence Director and/or designee will perform random weekly audits of resident service plans to ensure accuracy of the assessment and to ensure continued compliance for a period of 6 months. Findings will be reviewed through the Emerald House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>families educating them not to assist other residents from the building, this will be covered in Family Nights also. Door alarm placed on door to alert for closer observation that he is out of room.</p> <p>The DON provided a copy of a "Behavior Strategy Plan" for Resident A on 09/18/12 at 9:30 a.m. The DON indicated the form was originated the day Resident A was admitted to the facility (08/20/12). The form indicated, "Behavioral Concern: Resident last mini mental suggestive of cognitive impairment 2ndary (secondary) to D/X [diagnoses] of Dementia.....Resident is currently independent [symbol for with] ambulation [walking] without assistive device. Resident has potential to wander/exit seek. Current elopement score is 76. The goal is to decrease the risk for elopement. Potential Stimulus Triggering Behavior: Confusion; New environment (move in date 8/20/12); Potential Strategy to Control Stimuli: Staff to remove resident to area of decreased stimuli (i.e. redirect resident to rooms with low lights, turn on TV to a program of resident preference....Please re-direct from groups with other cognitively impaired residents that seem to potentiate the behavioral disturbance....organize an appropriate activity plan to occupy resident's attention (i.e. exercise, reminiscence therapy).</p>		<p>Designee will also perform random review of resident service plans to ensure continued compliance with the above referenced citation.</p> <p><b>By what date will the systemic changes be completed?</b> 11/5/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Staff to encourage these activities when resident exhibits behavioral disturbance. Staff to provide frequent safety checks to resident and redirect as needed. Resident has been identified as an elopement risk on the task sheet...Wanderguard in place, with routine checks for placement and function. Staff to document when behaviors are occurring and report appropriately." Hand written just under the last entry was, "Alarm placed on door at noc to alert staff of more frequent monitoring." The facility failed to apply or implement a Wanderguard as an intervention for the resident with high risk for elopement.</p> <p>Interview of the DON on 09/18/12 at 10:05 a.m., indicated Resident A had gone out the back door, which did not have a wander guard alarm on it. The DON indicated only the front door had a wander guard alarm. The DON indicated Resident A was not wearing a wander guard bracelet at the time he eloped. The DON indicated Resident A was "definitely an elopement risk." The DON indicated Resident A had left with a family member and requested the family member take him to a gas station. The DON indicated Resident A was found across the street from (local gas station) and had to cross highway 50 and was standing on a sidewalk. The DON</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated the resident got into the car with staff without any problem.</p> <p>Interview of LPN #1 on 09/18/12 at 10:02 a.m., indicated Resident A had an alarm on the door of his room which was set to sound at night but not during the day.</p> <p>Interview of the Administrator on 09/18/12 at 10:30 a.m., indicated Resident A went out the back door which was coded. The Administrator indicated a family entered the code so they could exit the back door and the resident went out with them. The Administrator indicated the family member entered the code so the door did not alarm. The Administrator indicated she had inserviced her staff to run to a door immediately anytime a door alarmed. The Administrator indicated she did not want to give the false security that if a resident has a wander guard then they don't have to worry about them. The DON indicated there were signs on front and back doors to educate families not to assist anyone out of the building without checking with nursing.</p> <p>On 09/18/12 at 10:45 a.m., all 9 exit doors were check with the DON present. All doors were observed to be coded for exit and were set to alarm when they were opened without the code. All doors were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>observed to have signs requesting visitors not assist anyone out the doors without first checking with nursing.</p> <p>Review of Resident A's clinical record on 09/18/12 at 11:20 a.m. indicated the following:</p> <p>Resident A was admitted to the facility on 08/20/12 with diagnoses which included, but were not limited to, dementia and anxiety. The resident had a past history of being a farmer and an outdoorsman.</p> <p>An "Elopement Risk Assessment," dated 08/17/12, indicated Resident A triggered a score of 76 on the assessment. The assessment form indicated if a resident triggered a score of 36-39, the Regional Director of Operations, the Regional Nurse Consultant and the Vice President were all to be consulted prior to admission and a resident who triggered this score "May require intervention to prevent escalation of risk. Contact the physician and family for discussion. Consider a Negotiated Risk..." The assessment form indicated a resident with a score of 40 or above were to be considered a "High risk for elopement."</p> <p>A "Folstein Mini Mental Status Examination" form, dated 08/17/12, indicated Resident A triggered a score of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>16. The Mini Mental Status form indicated a score of 24 or above was considered normal.</p> <p>A "Resident Services Notes," dated 08/20/12 at 8:30 a.m., indicated, "Resident arrived via car with family to be admitted to room....Resident has dementia, depression, anxiety. He will need to be monitored and reminders to bath. Will do own ADL's [activities of daily living] otherwise....Will need monitored at night d/t [due to] sundowners (increased confusion in the afternoon). Also has some hallucinations.</p> <p>A "Resident Services Notes," dated 08/23/12 at 9:00 a.m., indicated, "Resident roaming around up and down last night. Doesn't like staff checking on him during night, gets agitated. Spoke [symbol for with] Administrator it is ok not to go into his room during night. Staff notified."</p> <p>A "Resident Services Notes," dated 08/26/12 at 11:00 a.m. indicated, "Resident is asking staff for a ride to (a town near the facility) so we will watch him." No new interventions were implemented after the resident made this request.</p> <p>A "Resident Services Notes," dated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>08/26/12 at 2:00 p.m. indicated, "Resident went in car with another resident (sic) family and they dropped him off at gas station. Another resident's daughter seen him run to their car and knew who they were so I called them to see if they might have gave him a ride and they told me where they dropped him off at. Staff took off in their vehicle to look for him and found him at the auto parts place across from the gas station they left him at. He was very cooperative and got into staff car and came back [symbol for without] problem. Family was here at time and are with him at this time...."</p> <p>A "Folstein Mini Mental Status Examination" form, dated 08/26/12, indicated Resident A triggered a score of 12.</p> <p>"Resident Services Notes," dated 08/27/12 at 2:15 p.m., indicated, "Resident was giving (sic) a full body assessment [symbol for with] nothing noted @ this time."</p> <p>"Resident Services Notes," dated 09/08/12 at 4:00 p.m., indicated, "Resident very adamant he was leaving. Sat with resident and talked with him about the importance of him staying here and that he remain calm and not try to leave facility. Seemed to think he was in</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>jail (sic) wanted to call sister....This nurse let him call and seemed to calm him some (sic) waiting on her to call him back."</p> <p>An Assessment and Negotiated Service Plan Summary, dated 09/14/12, indicated, "....Orientation/Behavior Safety...Due to new environment monitor for Elopement Risk- Sundowns - Monitor closely in evening - Loves Western channel and sweet tea. Keep low light on in bathroom at night with door partially open so he can find the bathroom. ELOPEMENT RISK - monitor for safety.</p> <p>"Resident Service Notes," dated 09/14/12 at 12:00 p.m., indicated, "Resident was moved to room...to be closer to front of building.</p> <p>Documentation titled "Wandering" was provided by the DON on 09/18/12 at 10:10 a.m. This documentation was dated "(6/2008)." The documentation indicated, "....Monitor for any changes in the resident's status, needs, and/or preferences. Notify the Residence Director and/or other designated staff member of the changes. Make appropriate documentation in the resident's Service Notes. Some residents who suffer from dementia exhibit a tendency to wander. Some professionals believe that wandering occurs more</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2012	
NAME OF PROVIDER OR SUPPLIER  EMERALD HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>frequently in people who have always enjoyed the out-of-doors....Other causes of wandering may be stress from a confusing situation....The afflicted person may say 'I have to catch the next bus or I'll be late for work' or 'I have to get home.' Listed below are some of the most common inappropriate behaviors related to wandering, along with suggestions on how to resolve the problem behaviors:....Another resident of guest letting a resident out of the building...Address this issue in the monthly newsletter to residents and families and/or ensure that guests are aware that some residents need supervision outside the building. Ask them to notify staff if such a resident seeks assistance to leave the building;or leaves without supervision...."</p> <p>This State Residential finding relates to Complaint IN00115532.</p>						