STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDISON PLACE	2244 Q AVE, NEW CASTLE, , 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 467428. Intake 467428 - State Residential Findings related to the allegations are cited at R0052, R0090 and R0217. Survey dates: January 21 and 22, 2026 Facility number: 004426 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 30, 2026.	R 0000	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 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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 2/12/2026. The facility will ensure this requirement is met through the following corrective measures:	

R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (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, interview and record review, the facility failed to ensure a cognitively impaired resident received adequate supervision to prevent her from exiting the facility into the facility's secured exterior courtyard on 1/18/26, at approximately 6:00 a.m., while outdoor temperatures were around 11 degrees Fahrenheit. This deficient practice resulted in a cognitively impaired resident being outside unsupervised, exposed to potentially dangerous cold weather for 1 of 3 residents reviewed for neglect. (Resident B) Findings include: The clinical record of Resident B was reviewed on 1/21/26 at 2:50 p.m. The resident's	R 0052	R052 Resident Rights - Offense 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 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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 2/12/2026. The facility will ensure this requirement is met through the following corrective measures: 1 Resident B suffered no negative effects related to these findings. All staff to be in-serviced on elopement policy and procedures on 1/22/2026 2 Audit was conducted by ED on 1/22/2026 by to ensure all	02/12/2026

	diagnosis included, but was not limited to, unspecified dementia (a decline in mental abilities). A 90-day resident assessment, dated 12/9/25, indicated the resident's level of orientation "requires regular prompting due to confusion and disorientation ..." The resident had a behavior of defecating or urinating in inappropriate places and required staff assistance. The resident was cognitively impaired, and her overall elopement risk was documented as high. During an interview with the Executive Director (ED) on 1/21/26 at 3:00 p.m., the ED indicated Resident B did exit the building on the morning of 1/18/26, "without staff knowledge." The resident had ambulated from her room to the exit door near her room to the enclosed garden area. The resident ambulated very slowly. The night shift nursing assistant had gotten the resident up and dressed for the day around 5:45 a.m. The Certified Nurse Assistant (CNA) 4 then assisted Resident B to walk across the hall to another resident's room (Room 101). One of the nursing assistants on the opposite hall was the first person to see her sitting on the ground, on the pavement, outside of the door to the courtyard area. Around the same time, the day shift nurse heard the resident calling for		staff successfully complete elopement drills. 3 By 2/12/2026, current staff will be re-educated by ED elopement policy and procedures with passing grade for posttest to ensure comprehension. 4 The Executive Director is responsible for sustained compliance. The ED, or designee, will conduct an audit of staff comprehension, through elopement drills, 3x weekly for four weeks, weekly for four weeks, then bi-weekly monthly for one month. Results of the audit will be monitored with a conclusion of 3 consecutive months in full compliance.	

	help. The ED indicated, it was not unusual for the residents to check door handles to see if they could be opened. The doors to the courtyard were normally locked and we have not been able to determine why they were unlocked that morning. The resident would not have been out of sight for more than 15 to 30 minutes.			

	During an interview with CNA 4 on 1/22/26 at 9:35 a.m., the CNA indicated he had worked the night shift of 1/17/26 into 1/18/26 and did work with Resident B during that shift. The CNA had helped the resident get up and dressed by 5:40 a.m. He then helped her across the hall to another resident's room, Room 101. Before the CNA left for the day, he answered a call light in Room 105 at 5:45 a.m. When he answered the call light in Room 105, he witnessed the resident sitting on the couch in Room 101. The CNA left the facility around 6:00 a.m. and had not seen the resident again after 5:45 a.m. Resident B used to be up and down and wandered most of the nights but hasn't been like that for some time now. She has declined with her dementia, and she wasn't able to walk as well as she used to walk. The door the resident exited was the east door, near Room 107. The door was unlocked and he did not know why it was not locked. An observation of Room 101 and the location of the courtyard door (the resident exited) was within 25 feet or less. The door was currently locked at the time of observation. In a telephone interview with License Practical Nurse (LPN) 5 on 1/22/26 at 10:45 a.m., the LPN indicated when she came			

	on duty on 1/18/26, at 6:00 a.m., she was in the process of receiving report from the night shift Qualified Medication Aide (QMA), in the medication room, when they heard someone yell out. The QMA and LPN went down the hall immediately towards the yelling. There was a CNA there at the same time. "We found [name of Resident B] right outside the door to the courtyard ...She was dressed in a shirt, sweatshirt, pants, brief, socks ...about 6:15 a.m." The resident was assisted to her room and LPN 5 assessed her from head to toe. The resident has a slight abrasion on her right index finger, and her skin was cool to touch. The resident's temperature was 96.2, by a temporal thermometer. The resident's temperature gradually increased until the hospice nurse arrived and the resident's temperature was 97.5. The staff warmed up some blankets in the dryer and put them on the resident. The resident could not tell us what she was doing or why she had gone outside. The LPN indicated she was guessing that the resident was looking for the bathroom based on the position of her clothing. The resident's temperature was assessed about every 10 minutes, and it continued to climb slowly. The resident walked very slowly and not as steady as she had. The doors from the building to the			

	courtyard required a key to go outside, but did not require a key to re-enter the building from the courtyard. The door to the courtyard was normally locked and the facility asked the residents who went out to the courtyard to please remember to make sure the door was locked when they came back in. This time of year, especially as cold as it's been, not very many people have been going out to the courtyard. However, we do have at least one female resident that goes out to fill the bird feeders. The local weather was reviewed for 1/18/26 at 5:55 a.m. and the air temperature was 11 degrees with the wind speed of 7 miles per hour (mph) from the southwest. The local weather was reviewed for 1/18/26 at 6:15 a.m. and the air temperature was 11 degrees with wind speed at 7 miles mph from the west-southwest. The Weather.gov website, indicated frostbite can occur to exposed skin, within approximately 30 minutes, for temperatures of 10 degrees with a wind speed of 5 mph. The cdc.gov website, indicated cautioned for elderly persons "without food, clothing or heating," are at higher risk for frostbite or hypothermia.			

On 1/21/26 at 3:30 p.m., the ED provided a copy of the facility's "Admission Agreement," and indicated a copy of the "Resident's Rights," information was in the packet. The ED also indicated the facility follows all state regulations. The packet indicated the Resident's Rights was included in "Addendum D." Addendum D was not included in the provided information.

This citation relates to Intake 467428.

5-1.2(v)(5)

Based on observation, interview and record review, the facility failed to ensure a cognitively impaired resident received adequate supervision to prevent her from exiting the facility into the facility's secured exterior courtyard on 1/18/26, at approximately 6:00 a.m., while outdoor temperatures were around 11 degrees Fahrenheit. This deficient practice resulted in a cognitively impaired resident being outside unsupervised, exposed to potentially dangerous cold weather for 1 of 3 residents reviewed for neglect. (Resident B)

Findings include:

The clinical record of Resident B was reviewed on 1/21/26 at 2:50 p.m. The resident's diagnosis included, but was not

	limited to, unspecified dementia (a decline in mental abilities). A 90-day resident assessment, dated 12/9/25, indicated the resident's level of orientation "requires regular prompting due to confusion and disorientation ..." The resident had a behavior of defecating or urinating in inappropriate places and required staff assistance. The resident was cognitively impaired, and her overall elopement risk was documented as high. During an interview with the Executive Director (ED) on 1/21/26 at 3:00 p.m., the ED indicated Resident B did exit the building on the morning of 1/18/26, "without staff knowledge." The resident had ambulated from her room to the exit door near her room to the enclosed garden area. The resident ambulated very slowly. The night shift nursing assistant had gotten the resident up and dressed for the day around 5:45 a.m. The Certified Nurse Assistant (CNA) 4 then assisted Resident B to walk across the hall to another resident's room (Room 101). One of the nursing assistants on the opposite hall was the first person to see her sitting on the ground, on the pavement, outside of the door to the courtyard area. Around the same time, the day shift nurse heard the resident calling for help. The ED indicated, it was			

	not unusual for the residents to check door handles to see if they could be opened. The doors to the courtyard were normally locked and we have not been able to determine why they were unlocked that morning. The resident would not have been out of sight for more than 15 to 30 minutes. During an interview with CNA 4 on 1/22/26 at 9:35 a.m., the CNA indicated he had worked the night shift of 1/17/26 into 1/18/26 and did work with Resident B during that shift. The CNA had helped the resident get up and dressed by 5:40 a.m. He then helped her across the hall to another resident's room, Room 101. Before the CNA left for the day, he answered a call light in Room 105 at 5:45 a.m. When he answered the call light in Room 105, he witnessed the resident sitting on the couch in Room 101. The CNA left the facility around 6:00 a.m. and had not seen the resident again after 5:45 a.m. Resident B used to be up and down and wandered most of the nights but hasn't been like that for some time now. She has declined with her dementia, and she wasn't able to walk as well as she used to walk. The door the resident exited was the east door, near Room 107. The door was unlocked and he did not know why it was not locked.			

	An observation of Room 101 and the location of the courtyard door (the resident exited) was within 25 feet or less. The door was currently locked at the time of observation. In a telephone interview with License Practical Nurse (LPN) 5 on 1/22/26 at 10:45 a.m., the LPN indicated when she came on duty on 1/18/26, at 6:00 a.m., she was in the process of receiving report from the night shift Qualified Medication Aide (QMA), in the medication room, when they heard someone yell out. The QMA and LPN went down the hall immediately towards the yelling. There was a CNA there at the same time. "We found [name of Resident B] right outside the door to the courtyard ...She was dressed in a shirt, sweatshirt, pants, brief, socks ...about 6:15 a.m." The resident was assisted to her room and LPN 5 assessed her from head to toe. The resident has a slight abrasion on her right index finger, and her skin was cool to touch. The resident's temperature was 96.2, by a temporal thermometer. The resident's temperature gradually increased until the hospice nurse arrived and the resident's temperature was 97.5. The staff warmed up some blankets in the dryer and put them on the resident. The resident could not tell us what she was doing or why she had			

	gone outside. The LPN indicated she was guessing that the resident was looking for the bathroom based on the position of her clothing. The resident's temperature was assessed about every 10 minutes, and it continued to climb slowly. The resident walked very slowly and not as steady as she had. The doors from the building to the courtyard required a key to go outside, but did not require a key to re-enter the building from the courtyard. The door to the courtyard was normally locked and the facility asked the residents who went out to the courtyard to please remember to make sure the door was locked when they came back in. This time of year, especially as cold as it's been, not very many people have been going out to the courtyard. However, we do have at least one female resident that goes out to fill the bird feeders. The local weather was reviewed for 1/18/26 at 5:55 a.m. and the air temperature was 11 degrees with the wind speed of 7 miles per hour (mph) from the southwest. The local weather was reviewed for 1/18/26 at 6:15 a.m. and the air temperature was 11 degrees with wind speed at 7 miles mph from the west-southwest. The Weather.gov website, indicated frostbite can occur to			

	exposed skin, within approximately 30 minutes, for temperatures of 10 degrees with a wind speed of 5 mph. The cdc.gov website, indicated cautioned for elderly persons "without food, clothing or heating," are at higher risk for frostbite or hypothermia. On 1/21/26 at 3:30 p.m., the ED provided a copy of the facility's "Admission Agreement," and indicated a copy of the "Resident's Rights," information was in the packet. The ED also indicated the facility follows all state regulations. The packet indicated the Resident's Rights was included in "Addendum D." Addendum D was not included in the provided information. This citation relates to Intake 467428. 5-1.2(v)(5)			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare,	R 0090	R090 Administration and Management- Deficiency 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	02/12/2026

	safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility		be 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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 2/12/2026. The facility will ensure this requirement is met through the following corrective measures: 1 Resident B suffered no negative effects related to these findings. Executive Director was educated on the reporting guidelines for reportable incidents to the Indiana State Department of Health on 1/22/2026. 2 Audit was conducted on 1/22/2026 reviewing all clinical documentation to ensure all reportable incidents were reported to Indiana State Department of Health. 3 By 2/12/2026, current staff will be re-educated by ED on proper reporting guidelines, processes, and procedures.	

	conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to ensure an occurrence that directly threatened the welfare or health of a resident was reported within 24 hours to the Indiana Department of Health for 1 of 3 residents when a resident with a cognitive decline exited the building during a period of extremely cold temperatures without the knowledge of the staff. (Resident B) Findings include: During an interview with the Executive Director (ED) on 1/21/26 at 3:00 p.m., the ED indicated Resident B did exit the building on the morning of 1/18/26, "without staff knowledge." The resident had ambulated from her room to the exit door near her room to the enclosed garden area. The resident ambulated very slowly.		4 The Executive Director is responsible for sustained compliance. The Executive Director, or designee, will conduct an audit of staff completion of state reportable guidelines, processes, and procedures, 3 times a week for four weeks, weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be monitored with a conclusion of 3 consecutive months in full compliance.	

	One of the nursing assistants on the opposite hall was the first person to see her sitting on the ground, on the pavement, outside of the door to the courtyard area. "We identified this as an unwitnessed fall" and did not report as an unusual occurrence to the State Department of Health since the resident was not off the property. The doors to the courtyard were normally locked and the facility had not been able to determine why they were unlocked. The ED indicated the resident would not have been out of sight for more than 15 to 30 minutes. On 1/22/26 at 10:32 a.m., the ED indicated the facility did not have a policy that the doors to the courtyard must be locked from the interior of the facility to the outdoor courtyard. The clinical record of Resident B was reviewed on 1/21/26 at 2:50 p.m. The resident's diagnosis included, but was not limited to, unspecified dementia (a decline in mental abilities). A 90-day resident assessment, dated 12/9/25, indicated the resident's level of orientation "requires regular prompting due to confusion and disorientation ..." The resident required regular prompting due to confusion and disorientation, and she had difficulty communicating her needs. The local weather was reviewed			

	for 1/18/26 at 5:55 a.m. and the air temperature was 11 degrees with the wind speed of 7 miles per hour (mph) from the southwest. The local weather was reviewed for 1/18/26 at 6:15 a.m. and the air temperature was 11 degrees with wind speed at 7 miles mph from the west-southwest. The Weather.gov website, indicated frostbite can occur to exposed skin, within approximately 30 minutes, for temperatures of 10 degrees with a wind speed of 5 mph. The cdc.gov website, indicated cautioned for elderly persons "without food, clothing or heating," are at higher risk for frostbite or hypothermia.			

On 1/21/26 at 3:30 p.m., the ED provided a copy of the facility's policy entitled, "Incident Reports." This policy was dated 6/10/24. This policy indicated, "Injuries and unusual incidents will be reported in compliance with state regulatory requirements...The Community will furnish to the licensing agency within twenty-four (24) hours of becoming aware of any unusual occurrence that directly threatens the welfare or safety or health of a resident...Occurrence that directly threatens the welfare, safety or health of a resident [such as]...Neglect..."

This citation relates to Intake 467428.

5-1.3(g)(1)

Based on interview and record review, the facility failed to ensure an occurrence that directly threatened the welfare or health of a resident was reported within 24 hours to the Indiana Department of Health for 1 of 3 residents when a resident with a cognitive decline exited the building during a period of extremely cold temperatures without the knowledge of the staff. (Resident B)

Findings include:

During an interview with the Executive Director (ED) on

	1/21/26 at 3:00 p.m., the ED indicated Resident B did exit the building on the morning of 1/18/26, "without staff knowledge." The resident had ambulated from her room to the exit door near her room to the enclosed garden area. The resident ambulated very slowly. One of the nursing assistants on the opposite hall was the first person to see her sitting on the ground, on the pavement, outside of the door to the courtyard area. "We identified this as an unwitnessed fall" and did not report as an unusual occurrence to the State Department of Health since the resident was not off the property. The doors to the courtyard were normally locked and the facility had not been able to determine why they were unlocked. The ED indicated the resident would not have been out of sight for more than 15 to 30 minutes. On 1/22/26 at 10:32 a.m., the ED indicated the facility did not have a policy that the doors to the courtyard must be locked from the interior of the facility to the outdoor courtyard. The clinical record of Resident B was reviewed on 1/21/26 at 2:50 p.m. The resident's diagnosis included, but was not limited to, unspecified dementia (a decline in mental abilities). A 90-day resident assessment, dated 12/9/25, indicated the resident's level of orientation			

	"requires regular prompting due to confusion and disorientation ..." The resident required regular prompting due to confusion and disorientation, and she had difficulty communicating her needs. The local weather was reviewed for 1/18/26 at 5:55 a.m. and the air temperature was 11 degrees with the wind speed of 7 miles per hour (mph) from the southwest. The local weather was reviewed for 1/18/26 at 6:15 a.m. and the air temperature was 11 degrees with wind speed at 7 miles mph from the west-southwest. The Weather.gov website, indicated frostbite can occur to exposed skin, within approximately 30 minutes, for temperatures of 10 degrees with a wind speed of 5 mph. The cdc.gov website, indicated cautioned for elderly persons "without food, clothing or heating," are at higher risk for frostbite or hypothermia. On 1/21/26 at 3:30 p.m., the ED provided a copy of the facility's policy entitled, "Incident Reports." This policy was dated 6/10/24. This policy indicated, "Injuries and unusual incidents will be reported in compliance with state regulatory requirements...The Community will furnish to the licensing			

	agency within twenty-four (24) hours of becoming aware of any unusual occurrence that directly threatens the welfare or safety or health of a resident...Occurrence that directly threatens the welfare, safety or health of a resident [such as]...Neglect..." This citation relates to Intake 467428. 5-1.3(g)(1)			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (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: (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. (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	R 0217	R217 Evaluation- Deficiency 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 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. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper	02/12/2026

	or the resident may request a service plan review. (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. (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. (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. Based on interview and record review, the facility failed to complete a service plan for elopement risk, following the completion of an evaluation of the resident's care-related needs for 2 of 3 residents reviewed for elopement risk. (Resident C and Resident D) Findings include: 1.The clinical record of Resident C was reviewed on 1/22/26 at 11:46 a.m. The resident's diagnosis included, but was not limited to, dementia (decline in cognitive functions). A 90-day resident assessment, dated 1/6/26, indicated her level of orientation has "occasional		compliance in lieu of post survey review on or after 2/12/2026. The facility will ensure this requirement is met through the following corrective measures: 1 Resident C and Resident D suffered no negative effects related to these findings. Director of Health and Wellness educated on proper policy and procedure for completing a service plan for elopement risk of all residents on 1/22/2026. 2 Audit was conducted on 1/22/2026 by the Director of Health and Wellness of current residents to ensure proper service plan for elopement risk was completed on each resident. 3 By 2/12/2026, All residents will have an updated service plan for elopement risk. 4 The Executive Director is responsible for sustained compliance. The Director of Health and Wellness, or designee, will conduct an audit of resident service plans to ensure elopement risk was completed accurately, weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be monitored with a conclusion of 3 consecutive months in full compliance.	

confusion and difficulty recalling details. needs occasional prompting or orientation." Resident C's Score for Cognitive Impairment (SLUMS) test indicated she scored "10" points. SLUMS scoring indicated a person with a score of 1 to 19 was suggestive of dementia. The elopement risk evaluation indicated the resident had a diagnosis of dementia. The resident was highly mobile and liked to walk, with or without any type of device. Her overall elopement risk indicated the resident's risk for elopement was high. The most current risk assessment, dated 1/6/26, indicated, "Care Plan Task needed for Elopement Risk Evaluation?" The response to this inquiry was left blank. "Guidelines for Interpreting Scores," indicated the resident's assessment represented the potential for elopement and required an individualized service plan. A service plan for potential for elopement was not located in Resident C's clinical record.

During an interview on 1/22/26 at 2:50 p.m., the Director of Health and Wellness and the ED indicated with the current electronic health record (EHR) program used by facility for resident assessments, it provided a means to place the service plan for any identified concerns immediately after the

assessment in the document. They indicated this had not been being done routinely. Resident C's resident assessment was completed in the EHR, but the service plan was not necessarily completed for various areas throughout the assessment, including the elopement risk.

2. The clinical record of Resident D was reviewed on 1/22/26 at 12:13 p.m. The resident's diagnosis included, but was not limited to, unspecified dementia. A 90-day resident assessment, dated 11/30/25, indicated the resident's level of orientation required regular prompting due to confusion and disorientation. Resident D's SLUMS test indicated she scored "19" points. SLUMS scoring indicated a person with a score of 1 to 19 was suggestive of dementia. The elopement risk evaluation indicated she did not have a diagnosis of dementia. The resident had reduced mobility. Her overall elopement risk was calculated at "0," indicating Resident D was not at potential risk for elopement. However, if the elopement risk evaluation, area regarding a diagnosis of dementia had been answered correctly, she would have scored a "10," which would have identified Resident D as a potential elopement risk. "Guidelines for Interpreting

Scores," indicated a score of "1-30" represented the potential for elopement and required an individualized service plan. A service plan for potential for elopement was not located in Resident D's clinical record.

During an interview on 1/22/26 at 2:50 p.m., the Director of Health and Wellness and the ED indicated with the current electronic health record (EHR) program used by facility for resident assessments, it provided a means to place the service plan for any identified concerns immediately after the assessment in the document. They indicated this had not been being done routinely. Resident D's resident assessment was completed in the EHR, but the service plan was not necessarily completed for various areas throughout the assessment, including the elopement risk.

On 1/22/26 at 12:44 p.m., the ED provided a copy of a policy entitled, "Residential Assessments," dated 4/1/25. This policy indicated, "Assessments are completed and updated as frequently as necessary to ensure they reflect current resident care needs and preferences. The information from the Assessment is used to develop an appropriate plan of care...The Director of Health and Wellness is responsible for

completing resident Assessments...whenever an Assessment is updated, the Service Plan should also be updated...The Resident Assessment addresses...Functional capabilities, Mental conditions, Health and wellness, Resident safety...Other assessment tools include...Elopement Risk Assessment Tool..."

This citation relates to Intake 467428.

5.2(e)(1)(A)

5.2(e)(1)(B)

5.2(e)(1)(C)

5.2(e)(1)(D)

5.2(e)(2)

5.2(e)(3)

Based on interview and record review, the facility failed to complete a service plan for elopement risk, following the completion of an evaluation of the resident's care-related needs for 2 of 3 residents reviewed for elopement risk. (Resident C and Resident D)

Findings include:

1.The clinical record of Resident C was reviewed on 1/22/26 at 11:46 a.m. The resident's diagnosis included, but was not

limited to, dementia (decline in cognitive functions). A 90-day resident assessment, dated 1/6/26, indicated her level of orientation has "occasional confusion and difficulty recalling details. needs occasional prompting or orientation." Resident C's Score for Cognitive Impairment (SLUMS) test indicated she scored "10" points. SLUMS scoring indicated a person with a score of 1 to 19 was suggestive of dementia. The elopement risk evaluation indicated the resident had a diagnosis of dementia. The resident was highly mobile and liked to walk, with or without any type of device. Her overall elopement risk indicated the resident's risk for elopement was high. The most current risk assessment, dated 1/6/26, indicated, "Care Plan Task needed for Elopement Risk Evaluation?" The response to this inquiry was left blank. "Guidelines for Interpreting Scores," indicated the resident's assessment represented the potential for elopement and required an individualized service plan. A service plan for potential for elopement was not located in Resident C's clinical record.

During an interview on 1/22/26 at 2:50 p.m., the Director of Health and Wellness and the ED indicated with the current electronic health record (EHR)

program used by facility for resident assessments, it provided a means to place the service plan for any identified concerns immediately after the assessment in the document. They indicated this had not been being done routinely. Resident C's resident assessment was completed in the EHR, but the service plan was not necessarily completed for various areas throughout the assessment, including the elopement risk.

2. The clinical record of Resident D was reviewed on 1/22/26 at 12:13 p.m. The resident's diagnosis included, but was not limited to, unspecified dementia. A 90-day resident assessment, dated 11/30/25, indicated the resident's level of orientation required regular prompting due to confusion and disorientation. Resident D's SLUMS test indicated she scored "19" points. SLUMS scoring indicated a person with a score of 1 to 19 was suggestive of dementia. The elopement risk evaluation indicated she did not have a diagnosis of dementia. The resident had reduced mobility. Her overall elopement risk was calculated at "0," indicating Resident D was not at potential risk for elopement. However, if the elopement risk evaluation, area regarding a diagnosis of dementia had been

answered correctly, she would have scored a "10," which would have identified Resident D as a potential elopement risk. "Guidelines for Interpreting Scores," indicated a score of "1-30" represented the potential for elopement and required an individualized service plan. A service plan for potential for elopement was not located in Resident D's clinical record.

During an interview on 1/22/26 at 2:50 p.m., the Director of Health and Wellness and the ED indicated with the current electronic health record (EHR) program used by facility for resident assessments, it provided a means to place the service plan for any identified concerns immediately after the assessment in the document. They indicated this had not been being done routinely. Resident D's resident assessment was completed in the EHR, but the service plan was not necessarily completed for various areas throughout the assessment, including the elopement risk.

On 1/22/26 at 12:44 p.m., the ED provided a copy of a policy entitled, "Residential Assessments," dated 4/1/25. This policy indicated, "Assessments are completed and updated as frequently as necessary to ensure they reflect current resident care needs and

	preferences. The information from the Assessment is used to develop an appropriate plan of care...The Director of Health and Wellness is responsible for completing resident Assessments...whenever an Assessment is updated, the Service Plan should also be updated...The Resident Assessment addresses...Functional capabilities, Mental conditions, Health and wellness, Resident safety...Other assessment tools include...Elopement Risk Assessment Tool..." This citation relates to Intake 467428. 5.2(e)(1)(A) 5.2(e)(1)(B) 5.2(e)(1)(C) 5.2(e)(1)(D) 5.2(e)(2) 5.2(e)(3)			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREJackie Adams	TITLEDirector	(X6) DATE02/09/2026