STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT GARDEN PLAZA	8614 W 10TH ST, INDIANAPOLIS, , 46234

(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 Complaint IN00370525. Complaint IN00370525 - Substantiated. State deficiencies related to the allegations are cited at R0006 and R0052. Survey date: January 10, 2022. Facility number: 005616 Residential Census: 62 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 19, 2022.	R 0000		
R 0006	Scope of Residential Care - Deficiency 410 IAC 16.2-5-0.5(f)(1-5) (f) The resident must be discharged if the resident:	R 0006	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the	02/15/2022

	(1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on interview and record review, the facility failed to identify the need to re-assess and evaluate a resident to determine if they met criteria for an assisted living community following a change in condition, as evidenced by mental confusion, unsafe wandering, attempts of elopement, increased falls with an unsteady		statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be accomplished for those residents** **found to have been** **affected by the deficient practice;** The Residential Care Director or designee will review communication board and progress notes to ensure changes of conditions are communicated and reassessed. This will be ongoing. Resident B has not returned to community at this time. **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:** Review of last 30 days of progress notes of all residents will be conducted by nursing team to ensure that all changes of condition have been identified. The ED will review the	

	gait and an updated diagnosis of dementia which resulted in the resident eloping from the facility (Resident B) for 1 of 4 residents reviewed for criteria for assisted living. Findings include: During an interview on 1/10/22 at 5:00 a.m., Qualified Medication Aid (QMA) 4 indicated she was working the morning Resident B had been sent to the hospital. Resident B was confused and getting more confused over time. She would come out of her room during the night and early morning hours. She would try to go outside to get her car and go home. She did not have a car at the facility. Her apartment was close to the nursing office, and they could hear her door open, if they were in the office. QMA 4 would go out and talk with the resident and redirect her back to her apartment. On the date of the incident the resident had come out of her apartment and was wandering in the activity and lobby area. QMA 4 was passing medications. She gave Resident B her thyroid pill and redirected her back to her apartment. After QMA 4 finished her medication pass to the rest of the building and she went back to check on Resident B. The resident was not in her apartment. She checked the activities room, the dining room and the hall. She		findings of the progress notes. **What measures will be put into place or what systemic changes the facility will make to** **ensure that the deficient practice does not recur:** The Residential Care Director or designee will review communication board daily. Education of all clinical staff to ensure changes of conditions are communicated to the communication board. Any resident identified with a change of condition will have change of condition assessment and will be added to the retention log for 60 days. If a resident is identified as having a change of condition and updated assessment will be completed and care plan meeting will be scheduled with family to discuss safety plan. **How the corrective action(s) will be monitored to ensure**	

	was unable to locate the resident. She called the independent living receptionist to see if she had wandered over there. He had not seen her. QMA 4 then opened the door and looked outside. It was dark but she could hear the resident yelling "help" and called out to her. Resident B responded. The resident had fallen off the curb and was laying on the pavement, there was blood around her head. 911 was called and Resident B was taken to the hospital. She had not returned to the facility. On 1/10/22 at 9:00 a.m., during a telephone interview, Resident B's family member indicated Resident B had lived at the facility for several years. She had a new diagnosis of sundowner's (confusion at nighttime) dementia last year. The family had several conversations with the Corporate Assisted Living Director related to the resident's confusion. The resident had demonstrated a pattern of trying to elope and agitation at night. They had been notified the resident had tried to get out of the building the week before the incident of the elopement and fall. The family was told the facility would not "kick her out" due to her confusion and risk of escaping. The family thought that meant the facility had measures in place to keep her		**the** **deficient practice will not recur *I.e.,*** **what quality assurance program will be put into place;** The Executive Director will participate weekly in retention meeting in which the change of condition residents are reviewed. The results of the retention meeting findings will be part of the QMPI process. This will be ongoing. **By what date the systemic changes will be completed –** 2/15/2022	

	safe. The resident sustained a laceration to the head, a L1 (lumbar, back) compression fracture (broken bone) and a subarachnoid (the area between the brain and surrounding the tissue covering the brain) bleed from the fall. After the resident's discharge from the hospital, she had not been able to participate in therapy and was transferred to hospice. On 1/10/22 at 9:30 a.m., Resident B's medical record was reviewed. The diagnoses included, but was not limited to, dementia without behavioral disturbance, major depressive disorder, and encephalopathy (decreased function of the brain). On 9/29/21 at 5:14 p.m., a service plan update note indicated a care plan meeting was held. The resident and 2 family members were present. The progress note indicated the resident went from a level 3 to a level 4 for care (demonstrated increased care assistance needs).			

	A review of the most recent service plan, dated 9/29/21 and closed 12/30/21, indicated Resident B had resided at the facility since 2018 and did not address Resident B's new diagnosis of dementia, confusion, or her risk for elopement. On 12/2/21 a physician's note indicated the resident was seen by the Nurse Practitioner (NP) after a fall with no injury. The note indicated, "...The resident was sitting at the dining table with her daughter. Resident was more talkative than usual ...Does the patient need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? YES ...Has the patient noticed any hearing difficulties? YES ...Functional Finding: Does the patient need assistance with bathing, dressing, feeding, toileting and transfers? YES ...Cognitive Functioning Finding: Does the patient have difficulty using decision making strategies and difficulty directing attention? YES ...Psych: Alert and oriented to person...Assessment Accidental fall modified 2 Dec. 2021, Dementia unspecified without behavioral disturbance modified 16 Nov 2021, Difficulty eating, feeding difficulties modified 26 Oct 2021, Age-Related cognitive decline modified 11 April 2020,			

Age related debility modified 12 Jan, 2019...Plan: Dementia Pt is taking Namenda [medication for dementia]. SLUMS (St Louis University Mental Screen) : 7 ...Will re-check in 3 months. Family does not want to start on cognitive enhancing medication at this time...."

The last documented elopement risk screening was dated 9/13/21 and indicated the resident was not at risk of elopement with a score of 6.

On 9/28/21 at 3:40 p.m., a progress note indicated the resident's daughter had reported concerns, Resident B was "not acting right." She was not able to recall how to play a game of Rummikub during the visit. The facility advised to have the resident seen by her physician.

On 10/27/21 a St Louis University Mental Status (SLUMS) examination indicated Resident B had dementia with a score of 7 out of 30.

On 10/27/21 at 10:47 p.m., a progress note indicated the resident was up in the hall checking to see if anything was going on in activities. "This is very unusual behavior for this resident." She was reminded of the time of day, vital signs were checked, and she went back to her apartment.

	On 11/5/21 at 3:22 p.m., a health progress note indicated the daughter came to the Resident Care Director (RCD) and asked about the resident's cognitive decline and thoughts on Memory Care. Family considering move to Memory Care due to rapid decline. Resident has been unable to participate in games with family the past couple weeks. The staff recommended a UA (urinalysis) to determine if there was a urinary tract infection. On 11/7/21 at 12:17 p.m., a progress note indicated the family was notified the resident's UA lab test was negative for infection. The family was also notified of increased wandering at night, reported by the night shift QMA. On 11/15/21 at 9:06 a.m., a family communication note indicated family had increased concerns related to the progression of the resident's dementia. They were looking into moving her to a Memory Care. The medication orders included but were not limited to Namenda (dementia medication) give one 5 milligrams (mg) tablet in the morning for dementia with a start date of 11/17/21 On 11/18/21 at 8:34 p.m., a progress note indicated the			

	writer was notified by the CNA the resident attempted to open the exit doors and kept asking where her car was. On 11/20/21 at 5:03 p.m., a progress note indicated the resident could not remember how to get to her room from the dining area. On 11/22/21 at 5:54 a.m., a behavior note indicated Resident B was observed multiple times outside of apartment in pajamas, once by the front desk asking for the best way to get out so she could find her car. Indicated she needed to go home. On 11/22/21 at 6:30 a.m., alert note, daughter notified resident was trying to leave in a car and was exit seeking. Daughter spoke with resident on the phone. On 11/29/21 at 2:40 a.m., health status note, Resident B was out in the hall in pajamas. On 12/7/21 at 10:51 p.m., a behavior note indicated resident was out of apartment multiple times this shift. Resident refusing to return to apartment when requested by staff. Resident has been walking around the facility and returned on her own thus far. On 12/8/21 at 4:32 a.m., a behavior note indicated			

	Resident B was observed by the CNA going out of an exit during rounds. Resident stated looking for car. "Resident came back to apartment but is currently back out wandering around. Will not cooperate with staff for redirection. Will report to charge nurse." On 12/18/21 at 5:27 a.m., a transfer to the hospital summary indicated, "Writer went to apartment to check on resident at 5 a.m. Resident was not in apartment at this time. Writer walked around the first floor, called IL receptionist to alert them of resident not being seen and to keep an eye out. Writer went to multipurpose room and looked outside. Resident observed laying in parking lot on stomach and blood coming from head. Resident was yelling for help. 911 called and taken to unknown hospital at this time." Family, AL Director, M.D. and ED were notified. On 1/10/22 at 7:00 a.m., during an interview the Executive Director (ED) indicated the corporate has policies in place for admission criteria to determine if a resident met guidelines for assisted living. Resident B met those criteria. She had been at the facility since 12/31/18. If the resident's condition would change during their stay they would be re-evaluated. The facility had			

	multiple conversations with her family related to her behaviors just prior to the incident. This was all outlined in the medical record and the service plan. On 1/10/22 at 10:49 a.m., the Executive Director (ED) provided a current policy, dated 10/1/10 and revised 7/30/21, titled "Exit-Seeking Residents and Elopement." This policy indicated "Residents have the right to live at ease in a safe and secure environment. The community is responsible for ensuring effective systems are implemented to reduce risk of elopement by residents. The community will identify exit-seeking residents to minimize resident safety risks...After move-in, if a resident demonstrates exit-seeking behavior, talks about leaving, or attempts to leave alone, an Elopement Risk assessment will be completed. If the assessment indicates the resident is at risk for elopement, the ED with assistance from the RCD will determine which preventive measures, up to and including discharge to a secure facility, will be put in place..." On 1/10/22 at 10:49 a.m., the ED provided a current policy, dated 8/19/11, titled "Move-in Process." This policy indicated " Each resident moving into the community must meet admission criteria per the state's			

	regulations for assisted living. Proper documentation will be gathered to ensure resident's needs can be met in assisted living. Note: State Regulations supersede company policy...Move-in Criteria: Specific medical criteria for admission/move-in include: (follow state regulations)...Able to perform activities of daily living with personal supervision or assistance if necessary including ambulation, grooming, bathing, toileting, eating and dressing...Not a danger to self or others as determined by physician...does not require 24 hour nursing supervision..." This State Residential Finding relates to Complaint IN00370525. Based on interview and record review, the facility failed to identify the need to re-assess and evaluate a resident to determine if they met criteria for an assisted living community following a change in condition, as evidenced by mental confusion, unsafe wandering, attempts of elopement, increased falls with an unsteady gait and an updated diagnosis of dementia which resulted in the resident eloping from the facility (Resident B) for 1 of 4 residents reviewed for criteria for assisted living.			

	Findings include: During an interview on 1/10/22 at 5:00 a.m., Qualified Medication Aid (QMA) 4 indicated she was working the morning Resident B had been sent to the hospital. Resident B was confused and getting more confused over time. She would come out of her room during the night and early morning hours. She would try to go outside to get her car and go home. She did not have a car at the facility. Her apartment was close to the nursing office, and they could hear her door open, if they were in the office. QMA 4 would go out and talk with the resident and redirect her back to her apartment. On the date of the incident the resident had come out of her apartment and was wandering in the activity and lobby area. QMA 4 was passing medications. She gave Resident B her thyroid pill and redirected her back to her apartment. After QMA 4 finished her medication pass to the rest of the building and she went back to check on Resident B. The resident was not in her apartment. She checked the activities room, the dining room and the hall. She was unable to locate the resident. She called the independent living receptionist to see if she had wandered over there. He had not seen her. QMA 4 then opened the door and looked outside. It was dark			

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	multiple conversations with her family related to her behaviors just prior to the incident. This was all outlined in the medical record and the service plan. On 1/10/22 at 10:49 a.m., the Executive Director (ED) provided a current policy, dated 10/1/10 and revised 7/30/21, titled "Exit-Seeking Residents and Elopement." This policy indicated "Residents have the right to live at ease in a safe and secure environment. The community is responsible for ensuring effective systems are implemented to reduce risk of elopement by residents. The community will identify exit-seeking residents to minimize resident safety risks...After move-in, if a resident demonstrates exit-seeking behavior, talks about leaving, or attempts to leave alone, an Elopement Risk assessment will be completed. If the assessment indicates the resident is at risk for elopement, the ED with assistance from the RCD will determine which preventive measures, up to and including discharge to a secure facility, will be put in place..." On 1/10/22 at 10:49 a.m., the ED provided a current policy, dated 8/19/11, titled "Move-in Process." This policy indicated " Each resident moving into the community must meet admission criteria per the state's			

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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 interview and record	R 0052	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **What corrective action(s) will be accomplished for those residents found to have been**	02/15/2022

	review, the facility failed to assess and put interventions in place to prevent a confused resident with a diagnosis of dementia from leaving the facility without supervision resulting in harm when she fell sustaining a laceration to the head, a L1 (lumbar, back) compression fracture (broken bone) and a subarachnoid (the area between the brain and surrounding the tissue covering the brain) bleed for 1 of 3 residents reviewed for the potential elopement (Resident B). The facility failed to implement interventions for another resident with the potential for elopement for 1 of 3 residents reviewed for the potential elopement (Resident C). Findings include: 1. During an interview on 1/10/22 at 5:00 a.m., Qualified Medication Aid (QMA) 4 indicated she was working the morning Resident B had been sent to the hospital. Resident B was confused and getting more confused over time. She would come out of her room during the night and early morning hours. She would try to go outside to get her car and go home. She did not have a car at the facility. Her apartment was close to the nursing office, and they could hear her door open, if they were in the office. QMA 4 would go		**affected by the deficient practice:** Resident B has not returned to the community. Upon review of progress notes for the last 30 days of all resident's elopement assessment and SLUMS will be updated if applicable. **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;** Review of last 30 days of progress notes will be conducted by nursing team to ensure that all changes of condition have been identified. If elopement and change of mental status is identified, the elopement assessment and SLUMs will be updated. **What measures will be put into place or what systemic changes the facility will make to**	

	out and talk with the resident and redirect her back to her apartment. On the date of the incident the resident had come out of her apartment and was wandering in the activity and lobby area. QMA 4 was passing medications. She gave Resident B her thyroid pill and redirected her back to her apartment. After QMA 4 finished her medication pass to the rest of the building and she went back to check on Resident B. The resident was not in her apartment. She checked the activities room, the dining room and the hall. She was unable to locate the resident. She called the independent living receptionist to see if she had wandered over there. He had not seen her. QMA 4 then opened the door and looked outside. It was dark but she could hear the resident yelling "help" and called out to her. Resident B responded. The resident had fallen off the curb and was laying on the pavement, there was blood around her head. 911 was called and Resident B was taken to the hospital. She had not returned to the facility. During an observation of the assisted living (AL), on 1/10/22 at 5:30 a.m., there were no residents out in the hallways. The building had residents who resided on 3 floors. The first floor had several unlocked doors to the outside and a long		**ensure that the deficient practice does not recur;** SLUMS will be completed on each admission, readmission, Q6 months and if change of condition. Elopement assessment will be completed all new admissions, readmission, quarterly. If resident is at risk for elopement, care plan meeting will be scheduled with family to discuss safety plan.	

	hallway to the independent living facility with additional doors to the outside. Once outside the AL building the doors were locked. A staff member had to open the door from the inside to allow access back into the building. During the entrance conference, on 1/10/22 at 7:00 a.m., the Executive Director provided maps of the building, which identified 3 floors of residents, a resident list and a nursing employee work schedule for the week. The building had 150 apartments, of which 62 were occupied. The nursing scheduled indicated 2 nursing staff members were scheduled on the night shift, QMA 4 and Certified Nursing Assistant (CNA) 5. On 1/10/22 at 9:00 a.m., during a telephone interview, Resident B's family member indicated Resident B had lived at the facility for several years. She had a new diagnosis of sundowner's (confusion at nighttime) dementia last year. The family had several conversations with the Corporate Assisted Living Director related to the resident's confusion. The resident had demonstrated a pattern of trying to elope and agitation at night. They had been notified the resident had tried to get out of the building the week before the		**How 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;** The Executive Director will participate weekly in retention meeting in which the change of condition residents are reviewed. The Executive Director will notify and meet with family if resident is no longer appropriate for Assisted Living based on assessment findings. The results of the retention meeting findings will be part of the QMPI process. This will be ongoing **By what date the systemic changes will be completed –** 2/15/2022	

incident of the elopement and fall. The family was told the facility would not "kick her out" due to her confusion and risk of escaping. The family thought that meant the facility had measures in place to keep her safe. The resident sustained a laceration to the head, a L1 (lumbar, back) compression fracture (broken bone) and a subarachnoid (the area between the brain and surrounding the tissue covering the brain) bleed from the fall. After the resident's discharge from the hospital, she had not been able to participate in therapy and was transferred to hospice.

On 1/10/22 at 9:30 a.m., Resident B's medical record was reviewed. The diagnoses included, but was not limited to, dementia without behavioral disturbance, major depressive disorder, and encephalopathy (decreased function of the brain).

The medication orders included but were not limited to Namenda (dementia medication) give one 5 milligrams (mg) tablet in the morning for dementia with a start date of 11/17/21.

The last documented elopement risk screening was dated 9/13/21 and indicated the resident was not at risk of elopement with a score of 6.

On 10/27/21 a St Louis University Mental Status (SLUMS) examination indicated Resident B had dementia with a score of 7 out of 30.

A review of the most recent service plan, dated 9/29/21 and closed 12/30/21, did not address Resident B's new diagnosis of dementia, confusion, or her risk for elopement.

On 9/28/21 at 3:40 p.m., a progress note indicated the resident's daughter had reported concerns, Resident B was "not acting right." She was not able to recall how to play a game of Rummikub during the visit. The facility advised to have the resident seen by her physician.

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	the time of day, vital signs were checked, and she went back to her apartment. On 11/5/21 at 3:22 p.m., a health progress note indicated the daughter came to the Resident Care Director (RCD) and asked about the resident's cognitive decline and her thoughts on Memory Care. Family was considering a move to Memory Care due to the resident's rapid decline. Resident B had been unable to participate in games with family the past couple weeks. The staff recommended a UA (urinalysis to determine if there was a urinary tract infection). On 11/7/21 at 12:17 p.m., a progress note indicated the family was notified the resident's UA lab test was negative for infection. The family was also notified of increased wandering at night, reported by the night shift QMA.			

On 11/15/21 at 9:06 a.m., a family communication note indicated family had increased concerns related to the progression of the resident's dementia. They were looking into moving her to a Memory Care. The administration encouraged the family to purchase a dementia clock, since they had concerns about the resident getting times mixed up.

On 11/18/21 at 8:34 p.m., a progress note indicated the writer was notified by the CNA the resident attempted to open the exit doors and kept asking where her car was.

On 11/20/21 at 5:03 p.m., a progress note indicated the resident could not remember how to get to her room from the dining area.

On 11/22/21 at 5:54 a.m., a behavior note indicated Resident B was observed multiple times outside of apartment in pajamas, once by the front desk asking for the best way to get out so she could find her car. She indicated she needed to go home. Resident B was taken back to her apartment and shown where her clothes were. "Asked to get dressed so men wouldn't see her. Distracted the resident for now."

	On 11/22/21 at 6:30 a.m., alert note, daughter notified resident was trying to leave in a car and was exit seeking. Daughter spoke with resident on the phone. On 11/29/21 at 2:40 a.m., health status note, Resident B was out in the hall in pajamas. Resident reminded of the time and stated she didn't care. She indicated she was not going back to her apartment. Writer observed the resident go to activities and the dining room. She returned to her apartment on her own. On 12/2/21 at 9:51 a.m., an incident note indicated the CNA reported to the writer that the resident was on the floor. Resident was observed on the floor by the kitchen table. Vital signs (V/S) were taken, and no injuries noted. Resident was assisted to her chair. AL Director and the daughter were notified.			

On 12/2/21 a physician's note indicated the resident was seen by the Nurse Practitioner (NP) after a fall with no injury. The resident was sitting at the dining table with her daughter. Resident was more talkative than usual. No other concerns. The assessment indicated accidental fall, dementia, age related cognitive decline, difficulty eating, and debility. No changes made.

On 12/4/21 at 10:16 a.m., a fall follow-up note indicated the resident ambulated per self with a rolling walker and unsteady gait at times.

On 12/7/21 at 10:51 p.m., a behavior note indicated resident was out of apartment multiple times this shift. Resident refusing to return to apartment when requested by staff. Resident has been walking around the facility and returned on her own.

On 12/8/21 at 4:32 a.m., a behavior note indicated Resident B was observed by the CNA going out of an exit during rounds. Resident stated looking for car. "Resident came back to apartment but is currently back out wandering around. Will not cooperate with staff for redirection. Will report to charge nurse."

On 12/18/21 at 5:27 a.m., a

transfer to the hospital summary indicated, "Writer went to apartment to check on resident at 5 a.m. Resident was not in apartment at this time. Writer walked around the first floor, called IL receptionist to alert them of resident not being seen and to keep an eye out. Writer went to multipurpose room and looked outside. Resident observed laying in parking lot on stomach and blood coming from head. Resident was yelling for help. 911 called and taken to unknown hospital at this time." Family, AL Director, M.D. and ED were notified.

On 1/10/22 at 7:00 a.m., during an interview the Executive Director (ED) indicated the corporate had policies in place for admission criteria to determine if a resident met guidelines for assisted living. Resident B met those criteria. She had been at the facility since 2018. If a resident's condition changed during their stay they would be revaluated. The facility had multiple conversations with her family related to her behaviors just prior to the incident. This was all outlined in the medical record and the service plan.

On 1/10/22 at 12:20 p.m., during an interview, the Resident Care Director (RCD) indicated elopement evaluations were done on admission,

re-admission and for a change in condition.

2. On 1/10/22 at 11:00 a.m., the medical record was reviewed for Resident C. The diagnoses included but were not limited to heart failure and cognitive communication deficit.

On 8/26/21 a Re-Entry elopement risk screening indicated Resident C was high risk for elopement with a score of 24. The instructions indicated if the score was 10 or greater the resident must be considered at risk for elopement. Prevention protocols should be followed and documented on the service plan. Staff were to complete a SLUMS (St Louis University Mental Status) evaluation.

On 12/7/21 a comprehensive elopement risk screening indicated Resident C was high risk for elopement with a score of 24. The instructions indicated if the score was 10 or greater the resident must be considered at risk for elopement. Prevention protocols should be followed and documented on the service plan. Staff were to complete a SLUMS evaluation.

On 1/10/22 at 11:37 a.m., an undated SLUMS examination (paper copy) for Resident C was provided by the RCD. This document indicated Resident C had a score of 11 out of 30

which represented a diagnosis of dementia for a score between 1 and 20.

A review of Resident C's most recent service plan, dated 5/20/21 and completed 12/7/21, addressed behaviors related to refusal of showers at times, agitation and opening other residents' unlocked apartment doors and trying to enter other locked apartments. The elopement risk or SLUMS evaluation was not addressed in the service plan. Dementia was not listed on the resident's diagnosis list.

On 1/10/22 at 10:49 a.m., the Executive Director (ED) provided a current policy dated 10/1/10 and revised 7/30/21, titled "Exit-Seeking Residents and Elopement." This policy indicated "Residents have the right to live at ease in a safe and secure environment. The community is responsible for ensuring effective systems are implemented to reduce risk of elopement by residents. The community will identify exit-seeking residents to minimize resident safety risks...After move-in, if a resident demonstrates exit-seeking behavior, talks about leaving, or attempts to leave alone, an Elopement Risk assessment will be completed. If the assessment indicates the resident is at risk for elopement,

the ED with assistance from the RCD will determine which preventive measures, up to and including discharge to a secure facility, will be put in place..."

This State Residential Finding relates to Complaint IN00370525.

Based on interview and record review, the facility failed to assess and put interventions in place to prevent a confused resident with a diagnosis of dementia from leaving the facility without supervision resulting in harm when she fell sustaining a laceration to the head, a L1 (lumbar, back) compression fracture (broken bone) and a subarachnoid (the area between the brain and surrounding the tissue covering the brain) bleed for 1 of 3 residents reviewed for the potential elopement (Resident B). The facility failed to implement interventions for another resident with the potential for elopement for 1 of 3 residents reviewed for the potential elopement (Resident C).

Findings include:

1. During an interview on 1/10/22 at 5:00 a.m., Qualified Medication Aid (QMA) 4 indicated she was working the morning Resident B had been sent to the hospital. Resident B

was confused and getting more confused over time. She would come out of her room during the night and early morning hours. She would try to go outside to get her car and go home. She did not have a car at the facility. Her apartment was close to the nursing office, and they could hear her door open, if they were in the office. QMA 4 would go out and talk with the resident and redirect her back to her apartment. On the date of the incident the resident had come out of her apartment and was wandering in the activity and lobby area. QMA 4 was passing medications. She gave Resident B her thyroid pill and redirected her back to her apartment. After QMA 4 finished her medication pass to the rest of the building and she went back to check on Resident B. The resident was not in her apartment. She checked the activities room, the dining room and the hall. She was unable to locate the resident. She called the independent living receptionist to see if she had wandered over there. He had not seen her. QMA 4 then opened the door and looked outside. It was dark but she could hear the resident yelling "help" and called out to her. Resident B responded. The resident had fallen off the curb and was laying on the pavement, there was blood around her head. 911 was called and Resident B was

taken to the hospital. She had not returned to the facility.

During an observation of the assisted living (AL), on 1/10/22 at 5:30 a.m., there were no residents out in the hallways. The building had residents who resided on 3 floors. The first floor had several unlocked doors to the outside and a long hallway to the independent living facility with additional doors to the outside. Once outside the AL building the doors were locked. A staff member had to open the door from the inside to allow access back into the building.

During the entrance conference, on 1/10/22 at 7:00 a.m., the Executive Director provided maps of the building, which identified 3 floors of residents, a resident list and a nursing employee work schedule for the week. The building had 150 apartments, of which 62 were occupied. The nursing scheduled indicated 2 nursing staff members were scheduled on the night shift, QMA 4 and Certified Nursing Assistant (CNA) 5.

On 1/10/22 at 9:00 a.m., during a telephone interview, Resident B's family member indicated Resident B had lived at the facility for several years. She had a new diagnosis of sundowner's (confusion at

nighttime) dementia last year. The family had several conversations with the Corporate Assisted Living Director related to the resident's confusion. The resident had demonstrated a pattern of trying to elope and agitation at night. They had been notified the resident had tried to get out of the building the week before the incident of the elopement and fall. The family was told the facility would not "kick her out" due to her confusion and risk of escaping. The family thought that meant the facility had measures in place to keep her safe. The resident sustained a laceration to the head, a L1 (lumbar, back) compression fracture (broken bone) and a subarachnoid (the area between the brain and surrounding the tissue covering the brain) bleed from the fall. After the resident's discharge from the hospital, she had not been able to participate in therapy and was transferred to hospice.

On 1/10/22 at 9:30 a.m., Resident B's medical record was reviewed. The diagnoses included, but was not limited to, dementia without behavioral disturbance, major depressive disorder, and encephalopathy (decreased function of the brain).

The medication orders included but were not limited to Namenda

(dementia medication) give one 5 milligrams (mg) tablet in the morning for dementia with a start date of 11/17/21.

The last documented elopement risk screening was dated 9/13/21 and indicated the resident was not at risk of elopement with a score of 6.

On 10/27/21 a St Louis University Mental Status (SLUMS) examination indicated Resident B had dementia with a score of 7 out of 30.

A review of the most recent service plan, dated 9/29/21 and closed 12/30/21, did not address Resident B's new diagnosis of dementia, confusion, or her risk for elopement.

On 9/28/21 at 3:40 p.m., a progress note indicated the resident's daughter had reported concerns, Resident B was "not acting right." She was not able to recall how to play a game of Rummikub during the visit. The facility advised to have the resident seen by her physician.

On 9/29/21 at 5:14 p.m., a service plan update note indicated a care plan meeting was held. The resident and 2 family members were present. The progress note indicated the resident went from a level 3 to a level 4 for care (demonstrated

increased care assistance needs).

On 10/27/21 at 10:47 p.m., a progress note indicated the resident was up in the hall checking to see if anything was going on in activities. "This is very unusual behavior for this resident." She was reminded of the time of day, vital signs were checked, and she went back to her apartment.

On 11/5/21 at 3:22 p.m., a health progress note indicated the daughter came to the Resident Care Director (RCD) and asked about the resident's cognitive decline and her thoughts on Memory Care. Family was considering a move to Memory Care due to the resident's rapid decline. Resident B had been unable to participate in games with family the past couple weeks. The staff recommended a UA (urinalysis to determine if there was a urinary tract infection).

On 11/7/21 at 12:17 p.m., a progress note indicated the family was notified the resident's UA lab test was negative for infection. The family was also notified of increased wandering at night, reported by the night shift QMA.

On 11/15/21 at 9:06 a.m., a family communication note indicated family had increased

concerns related to the progression of the resident's dementia. They were looking into moving her to a Memory Care. The administration encouraged the family to purchase a dementia clock, since they had concerns about the resident getting times mixed up.

On 11/18/21 at 8:34 p.m., a progress note indicated the writer was notified by the CNA the resident attempted to open the exit doors and kept asking where her car was.

On 11/20/21 at 5:03 p.m., a progress note indicated the resident could not remember how to get to her room from the dining area.

On 11/22/21 at 5:54 a.m., a behavior note indicated Resident B was observed multiple times outside of apartment in pajamas, once by the front desk asking for the best way to get out so she could find her car. She indicated she needed to go home. Resident B was taken back to her apartment and shown where her clothes were. "Asked to get dressed so men wouldn't see her. Distracted the resident for now."

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On 12/2/21 at 9:51 a.m., an incident note indicated the CNA reported to the writer that the resident was on the floor. Resident was observed on the floor by the kitchen table. Vital signs (V/S) were taken, and no injuries noted. Resident was assisted to her chair. AL Director and the daughter were notified.

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This State Residential Finding relates to Complaint IN00370525.

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 SIGNATURE	TITLE	(X6) DATE