STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF CASTLETON, LLC	8480 CRAIG ST, INDIANAPOLIS, , 46250

(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 Complaints IN00383169 and IN00384433. Complaint IN00383169 - Unsubstantiated due to lack of evidence. Complaint IN00384433 - Substantiated. State deficiencies related to the allegations were cited at R0052. Survey date: July 18, 2022 Facility number: 009894 Residential: 136 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 26, 2022.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be	R 0052	***R 052 Resident Rights – Offense***	08/05/2022

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 review, the facility failed to ensure a resident with a diagnosis of Alzheimer's disease was free from neglect, when she was let out of the facility by a staff member and wandered away from the facility grounds, without the staff knowing of her whereabouts for approximately five hours prior to the family requesting the staff to call 911 for their assistance, in the search for the missing resident for 1 of 1 resident reviewed for neglect (Resident E).

Finding includes:

An "Intake Information" document, dated 7/5/22, provided by IDOH (Indiana Department of Health) on 7/5/22 at 11:30 p.m., indicated an elopement event involving Resident E occurred on 7/1/22 at 5:20 p.m. The event was reported to the IDOH gateway (reporting system for an unusual

What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

- Resident #1 who exited the facility had no history of being exit seeking, had documentation from her PCP stating she had no signs of eloping.
- Resident had recent hospitalization for urinary track infection from 6/21/22 to 6/29/2022 but demonstrated no exit seeking behaviors upon return. Family had visited resident following return and also relayed no concerns of exit seeking behavior.
- Facility is not a locked memory care and we have no memory care onsite so residents are able to come and go on property as well as leave to go offsite. Residents are not required to sign out when they are outdoors for walks.

occurrence) on 7/2/22 at 11:43 a.m. The report indicated the nursing staff went to Resident E's apartment to administer her medication, but she was not in her apartment. Her sister had been at her apartment visiting with her earlier that day, so the nursing staff thought the sister may have come and taken her out and forgotten to sign her out. A phone call was placed to the sister, who indicated she had not taken the resident out for the evening. The staff members checked the inside and outside of the facility, including the facility grounds without any success in finding the resident. The police were notified when the staff were unable to locate the resident. The police came to the facility and after they began their search for Resident E, she was located down the street from the facility at an apartment complex.

The record for Resident E was reviewed on 7/18/22 at 5:30 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, kidney transplant, chronic kidney disease, chronic atrial fibrillation, diabetes mellitus type 2 and hypertension.

Resident E's personal service plan, dated 5/30/22, indicated her cognitive and psychosocial status required daily cues or reminders and reassurances

- Residents who are an elopement risk require relocation to a locked unit and the transfer is coordinated between the family and facility.
- Facility does complete an Elopement risk assessment upon admission as well as with change of condition and and every 6 months. Risk is categorized as low or high and on resident’s risk assessment she had low risk of elopement.
- Facility attempted to contact family at approximately 6pm when residents wasn’t seen in common areas or apartment to see if she went out with them as they had just been at facility a few hours prior. Facility received call back at approximately 8pm that resident was not with them. Facility immediately began full search of all apartments and common areas. When resident wasn’t located staff began searching outside. When resident

from the facility staff. She required minimal assistance from one staff member for transfers. She required set-up help from staff for dressing and grooming tasks for her safety. She ambulated independently without assistance from the nursing staff and she had a standard walker. She had a chronic condition known as diabetes mellitus type 2, which required specific care and monitoring of her blood sugars. She was receiving contracted services, which was home health care to provide Physical and Occupational therapy for her.

A Physician's note, dated 6/2/22, indicated the resident was diagnosed with Alzheimer's Dementia and post kidney transplant. She lived with a family member in another state, but recently was moved to Indiana to live with a family member here due to worsening memory problems and agitation. She was confused and had mild expressive aphasia and it was difficult for her to make complete sentences. She was started on Eliquis (a blood thinner) 5 mg (milligrams) two times a day by mouth on 6/2/22 and ended on 7/1/22. The review of symptoms indicated the resident complained of fatigue, memory loss, mental status change and insomnia. She was only alert to herself

still wasn't located DON was contacted
and POA updated that we were unable to locate.
Family on site at that time approx. 9-930 pm and police called and onsite to assist in search.

- Resident
was located safe, offsite by police between 11 – 11:30pm.

- Upon
knowing resident was missing, facilities
followed missing resident policy:

  - Checked
sign in and sign out log.
  - Conducted
thorough search of interior of building.
  - Conducted
thorough search of exterior of building and grounds.
  - Police
were notified.
  -

	and her daughter. She ambulated with a moderate ataxic gait (an uncoordinated walk with jerking motions of the upper body). Age related decline indicated she had a diagnosis of dementia without behavioral disturbance and Alzheimer disease and she would need memory care if her cognitive state worsened. She required 24 hour/7 days a week care and reminders for all means and ADL care. A progress note, dated 7/1/22 at 11:55 p.m., indicated Resident E was discovered missing after a nursing staff member went to her apartment to administer medication to her. After contacting a family member to ask if she had taken the resident out of the facility earlier in the evening and she had not, the entire inside and outside of the facility grounds including outside the facility grounds was searched. At that time, when Resident E was not located, the Police Department was notified and shortly thereafter, the Police located Resident E down the street at an apartment complex. A Confidential phone interview was conducted during the course of the survey. The Confidential interviewee indicated she was contacted by the Director of Nursing (DON) on 7/1/22 at approximately 9:00 p.m. She was informed her		Provided picture to police and last known outfit. • Staff documented incident in point click care. Investigation completed. • Incident was reported to ISDH within 24 hours guidelines. • Care Conference was held immediately following elopement with POA to determine next best steps for resident. Due to situation facility advised that resident would benefit from locked memory care unit as there was no way to say she couldn’t attempt to leave property again.	

	family member could not be found in the facility and the facility staff were searching inside and outside the facility for her. She had been communicating with other family members by text messages to keep up to date on her disappearance. She text her family member at 11:00 p.m., to ask if the Police had filed a silver alert for her yet. She told her family member it was a scary feeling knowing it was 11:00 p.m., and their family member had not been found yet. Later after the text, she received a phone call and was told Resident E was found by a Police officer at approximately 11:30 p.m., sitting on the ground by a wooded area. The Confidential Interviewee indicated the family was concerned regarding the length of time the facility took before the staff notified the Police Department about the resident being missing and her family member was all alone for six hours, with some of that time being in the dark and the resident did not know how to get back to the facility. A Confidential phone interview was conducted during the course of the survey. The Confidential interviewee indicated she was contacted by a staff member from the facility on 7/1/22 at approximately 6:30 p.m. She was asked if she had		• Immediately following incident all residents with diagnosis of Dementia reviewed and elopement risk assessment in place. No noted concerns of elopement risk. **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.** • Resident involved relocated to memory care unit following incident. • Facility will continue to complete an Elopement Risk Assessment on all residents with a diagnosis of dementia upon admission, with change of condition, and/or every 6 months. • If a resident is a high risk for elopement, they will either not be accepted into the	

	taken Resident E out for the evening and had forgotten to sign her out. Then, between the hours of 6:30 p.m. and 8:00 p.m., she and two other family members received phone calls from different facility staff members asking if they had the resident with them. At no time during any of the previous phone calls was there ever a time the facility staff mentioned the resident was missing, until 8:00 p.m., when one of the three family members asked where the resident was and what was going on. At that time, the staff member indicated the resident was missing from the facility. After communicating with the facility staff and each other, the family decided at 9:45 p.m., to go to the facility and assist in the search of the resident. She indicated the family arrived at the facility shortly before 10:00 p.m., and asked the staff if the police had been notified of their missing loved one. One of the staff members indicated they had not contacted the Police to report Resident E missing yet. A family member indicated he wanted the police called to help search for their loved one. Three Police officers arrived a little after 10:00 p.m., the DON arrived after the Police, then the ED (Executive Director) arrived. At that point, the staff had no idea what		community or if they are already a resident the facility will work with the family on selecting a memory care community for the resident. • An Elopement Risk Assessment Intake Form Audit Tool has been created that monitors all elopement assessments to ensure they are updated upon admission, with change of condition and/or every 6 months. The tool will be monitored weekly X 4 weeks then bi-monthly X 6 months. Results of the Audit Tool will be reviewed at bi-monthly CCR Meeting. **What Measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** • Staff education was completed on 8/5/2022 covering Wyndmoor's Missing Resident Policy and Missing Resident Response Worksheet.	

direction the resident had wandered off in and the family was concerned the resident may have fallen into the pond in back of the facility. The ED indicated the surveillance cameras was unable to be reviewed until a certain staff member (she could not remember who the staff member was) arrived to review them. At approximately 11:30 p.m., Resident E was found by a police officer. At that time, a Police officer was gathering information prior to the resident being found to start a Silver alert for Resident E. The family member responsible for the resident was driven to the site where the resident was located. When she arrived at the site, the resident was sitting in the road at the end of a pathway, which lead to a dead end street, surrounded by a field and apartment buildings.

The Confidential Interviewee indicated the Police officer told her and the other family members, he was concerned because the facility waited five hours after Resident E went missing, before a staff member called the police to assist in the search. The Confidential Interviewee indicated the main concerns the family had were the staff members did not notify the family right away Resident E was missing, the staff members did not call the Police Department to assist in the

Education will be ongoing.

- An Elopement Risk Assessment Intake Form Audit Tool has been created that monitors all elopement assessments to ensure they are updated upon admission, with change of condition and/or every 6 months. The tool will be monitored weekly X 4 weeks then bi-monthly X 6 months. Results of the Audit Tool will be reviewed at bi-monthly CCR Meeting.
- A Missing Resident Policy and Missing Resident Response Worksheet is available at the front desk to ensure ongoing resident safety.
- Signs remain posted reminding residents and family to sign and out when leaving property to ensure resident safety.
- Ongoing monthly elopement drills will be completed per company policy.
- An Elopement

search prior to a family member demanding the police be called when they arrived at the facility a few minutes before 10:00 p.m., and the resident was alone without food or drink on a hot evening, with her being a kidney transplant recipient, then being in the dark for approximately two hours by herself. When the police became involved, Resident E was located within an hour, so if the Police had been involved earlier in her disappearance, she would not have been left alone and lost without food or water, in the dark, sitting in the road, on a dead end street for over 6 hours. As soon as the Police were notified and got to the facility, they began searching and they knew just where to look for her because that was what they were trained to do.

During an interview, on 7/18/22 at 12:45 p.m., the DON indicated she, the ED (Executive Director) and a Police Officer were able to review how the resident exited the facility on the surveillance cameras once the Business Office Manager arrived to the facility that evening. Resident E came out of her apartment "all dressed up" and went out the front door of the facility on 7/1/22 at 5:15 p.m. She was found at 10:45 p.m. QMA 1 observed her leaving her

Drill Audit Tool has been created that monitors all monthly drills. This audit tool will be updated monthly and will ensure compliance with Wyndmoor Policy. Copy of Elopement Drill will be given to ED to ensure compliance by the Maintenance Director or designee. The Audit Tool will be updated monthly by the ED for 6 months to ensure continued compliance with the state requirement.

- The Elopement drill audit with be reviewed monthly at Collaborative care meeting to ensure compliance. In the event non-compliance is noted the ED will then determine if further corrective action is warranted, based on findings.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.

- An Elopement Risk Assessment Intake Form

	apartment and walking down the hallway right before she left the facility. QMA 1 thought she was going to dinner with her sister. The family visited often and took the resident out to eat frequently. QMA 1 went to deliver the resident her medication after dinner and realized she was not in her apartment and thought she was still out with her sister and they had forgotten to sign her out. She called the sister, who she was last visited by, to ask if she had taken her out, but she had to leave a message. After receiving a return call from the resident's sister indicating she had not taken the resident out from the facility earlier that day, staff thoroughly searched all areas of the inside of the facility and the facility grounds without locating the resident. Then staff began searching the perimeter outside of the facility grounds, including the neighborhood around the facility, on foot and driving their cars without locating her. The resident's family came to the facility, after being notified by facility staff, the resident was missing. The Police arrived at the facility at the same time as the DON arrived. The ED, DON and the Police reviewed the surveillance camera (after the BOM arrived at the facility because she was the only one who could go back and select		Audit Tool has been created that monitors all elopement assessments to ensure they are updated upon admission, with change of condition and/or every 6 months. The tool will be monitored weekly X 4 weeks then bi-monthly X 6 months. Results of the Audit Tool will be reviewed at bi-monthly CCR Meeting. • Ongoing monthly elopement drills will be completed per company policy. • An Elopement Drill Audit Tool has been created that monitors all monthly drills. This audit tool will be updated monthly and will ensure compliance with Wyndmoor Policy. Copy of Elopement Drill will be given to ED to ensure compliance by the Maintenance Director or designee. The Audit Tool will be updated monthly by the ED for 6 months to ensure continued compliance with the state requirement. • The Elopement drill audit with be reviewed monthly at	

	the video) of the resident exiting the facility. The DON indicated the Surveillance cameras tracked Resident E's movements showing she exited the front locked door after the Receptionist on duty unlocked the door for her (this information was discovered by an interview with the ED and the Receptionist on duty that day). The Receptionist (who only worked weekends) did not know the resident was a confused resident with Alzheimer's and was not safe to go outdoors by herself. The resident went from the front door, ambulated on the sidewalk around the property to the back terrace patio and sat down for a little while, then she got up and walked around the back knocking on windows and doors, while trying door handles to check if the doors would open, trying to get back into the facility. Then, she walked on the pathway leading from the back of the facility into a wooded area behind the facility, which eventually connected to an apartment complex. Many of their residents used that pathway as a shortcut to go to the shopping area on the other side of the wooded area because the pathway led right through the wooded area and saved them from having to walk through the housing neighborhood. After she walked		Collaborative care meeting to ensure compliance. In the event non-compliance is noted the ED will then determine if further corrective action is warranted, based on findings. **By what date the systemic changes will be completed.** • 8/5/2022	

into the wooded area, they were unable to see what direction she took when she exited the wooded area. The DON indicated she thought she and the Police arrived at the facility around 8:00 p.m., but she was unable to pull her texts and phone records up on her phone to verify the time. All the things involved with the incident were occurring so fast, she did not recall the time frames such as; when she called family members to confirm they had not taken the resident out for the night, when she and the Police arrived at the facility and what time the resident was located by the Police, she was almost sure it was 10:45 p.m.

During an interview, on 7/18/22 at 3:44 p.m., when asked to describe the elopement incident of Resident E on 7/1/22, QMA (Qualified Medication Aide) 1 indicated she observed Resident E's sister visiting with her at approximately 3:00 p.m. The resident laid down to take a nap after her sister's visit, then she was assisted down to the dining room by a CNA a few minutes after 5:00 p.m. She was dressed up cute in her jean capris, a nice blouse, tennis shoes and she had her purse. QMA 1 went into the resident's apartment after dinner (she could not remember the time) to administer her antibiotic and the resident was not in her

apartment. At that time, QMA 1 indicated she felt it was strange for Resident E not be in her apartment at that hour because she typically did not leave her apartment unless she was out with her family. She went downstairs to check the LOA (Leave of Absence) book to see if one of the family members had taken her out. She and the rest of the facility staff searched inside the entire facility, but was unable to locate the resident, so she called the resident's sister to ask if she had taken her out that night. There was no answer, so she left a message to have the sister return her call. The sister returned the call indicating Resident E was not with her. The DON called the daughter who lived locally and she indicated the family did not have the resident with them. She also informed the DON she and the rest of the family members were on their way to the facility to help search for her mother. The staff members continued to search inside the facility and they drove their cars around the perimeter of the facility, in the neighborhood, searching for her after the inside search was unsuccessful. The family had requested the police be called, when they arrived at the facility because the police had not been notified. The police showed up right before the DON. QMA 1 was unable to give specific time frames when

events occurred during this incident (for example; what time she first discovered the resident missing after dinner, when key persons, such as the family and police were called, and when key persons, such as the family and the police arrived at the facility). She indicated she was out in her car searching for Resident E until around midnight when the police located her.

A current facility policy, titled "Abuse, Neglect and Exploitation Policy," dated as revised on 01/01/2022 and provided by the ED on 7/18/22 at 4:00 p.m., indicated "Policy Overview: Wyndmoor is committed to maintaining a safe environment for each resident, visitor and employee. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up. Policy Detail...b. "Neglect" is defined in Indiana as an act or omission which places a resident in a situation that may endanger the resident's life or health; abandoning or cruelly confining a resident; or depriving a resident or necessary support, including food, shelter and medical care...."

A current facility policy, titled

"Resident Rights Know Your Rights under Federal Nursing Home Regulations," updated March 15, 2017 and provided by the ED on 7/18/22 at 2:36 p.m., indicated "Resident rights: You have the right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility...Respect and Dignity: You have a right to be treated with respect and dignity, including: The right to be free from abuse, neglect, misappropriation of your property, exploitation, corporal punishment or involuntary seclusion...Safe Environment: You have the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely...."

This State tag relates to Complaint IN00384433.

Based on interview and record review, the facility failed to ensure a resident with a diagnosis of Alzheimer's disease was free from neglect, when she was let out of the facility by a staff member and wandered away from the facility grounds, without the staff knowing of her whereabouts for approximately five hours prior to the family requesting the staff to call 911 for their assistance, in

the search for the missing resident for 1 of 1 resident reviewed for neglect (Resident E).

Finding includes:

An "Intake Information" document, dated 7/5/22, provided by IDOH (Indiana Department of Health) on 7/5/22 at 11:30 p.m., indicated an elopement event involving Resident E occurred on 7/1/22 at 5:20 p.m. The event was reported to the IDOH gateway (reporting system for an unusual occurrence) on 7/2/22 at 11:43 a.m. The report indicated the nursing staff went to Resident E's apartment to administer her medication, but she was not in her apartment. Her sister had been at her apartment visiting with her earlier that day, so the nursing staff thought the sister may have come and taken her out and forgotten to sign her out. A phone call was placed to the sister, who indicated she had not taken the resident out for the evening. The staff members checked the inside and outside of the facility, including the facility grounds without any success in finding the resident. The police were notified when the staff were unable to locate the resident. The police came to the facility and after they began their search for Resident E, she was located down the street from the

facility at an apartment complex.

The record for Resident E was reviewed on 7/18/22 at 5:30 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, kidney transplant, chronic kidney disease, chronic atrial fibrillation, diabetes mellitus type 2 and hypertension.

Resident E's personal service plan, dated 5/30/22, indicated her cognitive and psychosocial status required daily cues or reminders and reassurances from the facility staff. She required minimal assistance from one staff member for transfers. She required set-up help from staff for dressing and grooming tasks for her safety. She ambulated independently without assistance from the nursing staff and she had a standard walker. She had a chronic condition known as diabetes mellitus type 2, which required specific care and monitoring of her blood sugars. She was receiving contracted services, which was home health care to provide Physical and Occupational therapy for her.

A Physician's note, dated 6/2/22, indicated the resident was diagnosed with Alzheimer's Dementia and post kidney transplant. She lived with a family member in another state,

but recently was moved to Indiana to live with a family member here due to worsening memory problems and agitation. She was confused and had mild expressive aphasia and it was difficult for her to make complete sentences. She was started on Eliquis (a blood thinner) 5 mg (milligrams) two times a day by mouth on 6/2/22 and ended on 7/1/22. The review of symptoms indicated the resident complained of fatigue, memory loss, mental status change and insomnia. She was only alert to herself and her daughter. She ambulated with a moderate ataxic gait (an uncoordinated walk with jerking motions of the upper body). Age related decline indicated she had a diagnosis of dementia without behavioral disturbance and Alzheimer disease and she would need memory care if her cognitive state worsened. She required 24 hour/7 days a week care and reminders for all means and ADL care.

A progress note, dated 7/1/22 at 11:55 p.m., indicated Resident E was discovered missing after a nursing staff member went to her apartment to administer medication to her. After contacting a family member to ask if she had taken the resident out of the facility earlier in the evening and she had not, the entire inside and outside of

the facility grounds including outside the facility grounds was searched. At that time, when Resident E was not located, the Police Department was notified and shortly thereafter, the Police located Resident E down the street at an apartment complex.

A Confidential phone interview was conducted during the course of the survey. The Confidential interviewee indicated she was contacted by the Director of Nursing (DON) on 7/1/22 at approximately 9:00 p.m. She was informed her family member could not be found in the facility and the facility staff were searching inside and outside the facility for her. She had been communicating with other family members by text messages to keep up to date on her disappearance. She text her family member at 11:00 p.m., to ask if the Police had filed a silver alert for her yet. She told her family member it was a scary feeling knowing it was 11:00 p.m., and their family member had not been found yet. Later after the text, she received a phone call and was told Resident E was found by a Police officer at approximately 11:30 p.m., sitting on the ground by a wooded area. The Confidential Interviewee indicated the family was concerned regarding the length of time the facility took before

the staff notified the Police Department about the resident being missing and her family member was all alone for six hours, with some of that time being in the dark and the resident did not know how to get back to the facility.

A Confidential phone interview was conducted during the course of the survey. The Confidential interviewee indicated she was contacted by a staff member from the facility on 7/1/22 at approximately 6:30 p.m. She was asked if she had taken Resident E out for the evening and had forgotten to sign her out. Then, between the hours of 6:30 p.m. and 8:00 p.m., she and two other family members received phone calls from different facility staff members asking if they had the resident with them. At no time during any of the previous phone calls was there ever a time the facility staff mentioned the resident was missing, until 8:00 p.m., when one of the three family members asked where the resident was and what was going on. At that time, the staff member indicated the resident was missing from the facility. After communicating with the facility staff and each other, the family decided at 9:45 p.m., to go to the facility and assist in the search of the resident.

She indicated the family arrived at the facility shortly before 10:00 p.m., and asked the staff if the police had been notified of their missing loved one. One of the staff members indicated they had not contacted the Police to report Resident E missing yet. A family member indicated he wanted the police called to help search for their loved one. Three Police officers arrived a little after 10:00 p.m., the DON arrived after the Police, then the ED (Executive Director) arrived. At that point, the staff had no idea what direction the resident had wandered off in and the family was concerned the resident may have fallen into the pond in back of the facility. The ED indicated the surveillance cameras was unable to be reviewed until a certain staff member (she could not remember who the staff member was) arrived to review them. At approximately 11:30 p.m., Resident E was found by a police officer. At that time, a Police officer was gathering information prior to the resident being found to start a Silver alert for Resident E. The family member responsible for the resident was driven to the site where the resident was located. When she arrived at the site, the resident was sitting in the road at the end of a pathway, which lead to a dead end street, surrounded by a field and apartment buildings.

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