STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE WOODS	2335 N MADISON AVE, ANDERSON, , 46011

(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 IN00381022 and IN00381363. Complaint IN00381022 - Substantiated. State Residential Findings related to the allegations are cited at R0052. Complaint IN00381363 - Substantiated. No State Residential Findings related to the allegations were cited. Survey date: June 8, 2022. Facility number: 010409 Residential Census: 52 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality reveiw completed on June 15, 2022.	R 0000	**This plan of correction is submitted as required under State and Federal law.** **The submission of this Plan of Correction does not constitute an admission on the part of Keystone Woods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom.** **Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any**	

			proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.	
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 prevent elopement for 2 of 2 residents reviewed for elopement. (Resident C and Resident D). This deficient practice resulted in Resident C leaving the facility and being found 0.5 mile from the facility. Findings include:	R 0052	1. Residents C and D are no longer in the Community. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Executive Director and/or Wellness Director will conduct in-services to educate staff on increased exit seeking behaviors, including observing resident for such behavior. If a exist seeking behavior is observed, staff will report the behavior immediately to Wellness	06/30/2022

	1. Resident C's clinical record was reviewed on 6/8/22 10:52 a.m. Diagnoses included, but was not limited to, diabetes mellitus type II without complications, chronic depression, hypertension and osteoporosis. Her medications included, but was not limited to, atenolol (blood pressure) 12.5 mg daily, fluoxetine (antidepressant) 10 mg (milligram) daily and melatonin (promote sleep) 3 mg daily. A service plan, dated 3/23/22, indicated she was oriented to person and place. She had mild impairment: she had occasional disorientation to person, place, time or situation that did not interfere with functioning in familiar surroundings. May require some direction and reminding from others at times. She ambulated independently and did not require assistance. Her nurses notes indicated, but was not limited to the following: On 5/23/22 at approximately 4:30 a.m., writer had entered resident's room to give her her 5 a.m. pill, only to find her bed made and her MIA (Missing In Action). Writer immediately radioed staff to see if she had seen her. She indicated she had not. The lobby alarm started going off and they both went up		Director. In addition all residents will be assessed for elopement risk. 4. The Wellness Director or designee will monitor to ensure staff is observing and reporting exit seeking behaviors the Wellness Director. 5. The date the systemic changes will be completed by is June 30, 2022.	

front. The CNA went out first and didn't see anyone and then the writer went out and didn't see anyone. No one had signed in that they were there at the facility (temperature taken). They started going from room to room looking for anyone missing. After checking rooms, they had not checked the kitchen or back hall. A resident had turned on her call light on for pain medication. Writer indicated to the CNA she would check the kitchen if she would check the back hall. Before writer got to the kitchen the CNA radioed that Resident C was outside the employee entrance. Writer and the CNA met in the hall between the dining room and kitchen. Resident C had books in her arm and was carrying a baggy with tupperware salt and pepper shakers. Resident C stated she was looking for her husband. Writer indicated to her that she had scared her when she couldn't find her. She heard the alarm sounding and asked if she did that. The writer gave her her medication and the CNA walked her back to her room and asked her not to leave anymore without telling them first.

The clinical record lacked a head to toe assessment.

On 5/23/22 at 6:20 p.m., the nurse received a call pertaining to the resident had walked over

there [to a nearby residence] and the resident had stated she was going home, they asked her to stay there until staff could retrieve her. Her POA, Executive Director and DON was notified. She returned with no apparent injuries. She understood at that time that she lived at the facility. POA was asked to sit with resident and was at the facility.

On 5/24/22 (no document time), late entry for 5/23/22, when Resident C returned to facility writer did a head to toe assessment, no areas were noted, no complaint of fall or pain. Her clothes appeared clean and she denied pain or discomfort.

Review of www.google.com/maps indicated the residence she was retrieved from was 0.5 miles south of the facility and it was a nine minute walk. There were no sidewalks located on either side of the road. The terrain was grass from the facility to the concrete driveway of the church, that was located next to the facility. Next to the church was a distribution facility and there was grass from the driveway of the church to the distribution facility driveway. There were three entrances into the distribution facility and between the entrances was grass, a drain culvert and a sloped

drainage ditches located between the entrances. Located next to the facility was the residence that Resident C was retrieved from. From the third entrance of the distribution facility and the driveway of the residence was grass. The driveway of the residence was stone and the house was approximately 100 feet or more off the road. The terrain from the facility to the residence where she was retrieved from was uneven, except for near or on the road.

Review of the website localconditions.com for historical weather, indicated on May 23, 2022 at 3:15 a.m. the temperature was 50 degrees Fahrenheit at 4:15 a.m. it was 49 degrees and at 3:55 p.m. it was 64 degrees, at 7:55 p.m. it was 64 degrees.

During an interview and an observation of the employee entrance with the Administrator, on 6/8/22 at 9:11 a.m., she indicated they had no other residents in the facility that were at risk for elopement. There were two closed doors with a push handle on the left door and both doors had rectangle windows in them, the service area and doors with windows to the outside that led to the employee parking lot was visible. When the door to the employee parking lot was

opened an alarm did not sound. The CNA and nurse that worked that night were checking the service hall and kitchen, and found Resident C standing outside the employee entrance door. She indicated the doors were locked at 9 p.m. to be able to get in but were unlocked to leave.

During an interview with the Regional Nurse Consultant and the Administrator, on 6/8/22 at 11:06 a.m., the Administrator indicated the cameras did work but she did not have access to them. They did complete 15 minute checks and an inservice for the elopements. The Regional Nurse Consultant indicated new doorbells were placed on the doors. They were looking at getting a new security system and lock everything down. Resident C did leave after she had walked outside at 4:30 a.m. and she also left at 6:20 p.m. and was found at the villas behind the facility that used to be part of the facility. They were not sure what door she went out of or how long she had been gone either time.

During an interview with LPN 77 and QMA 72, on 6/8/22 at 2:12 p.m., LPN 77 indicated they had just seen Resident C at dinner between 4:30 p.m. and 5:30 p.m. She had received a phone call between 6:30 p.m. and 7:00 p.m., the caller indicated that

Resident C was at their home, she seemed to be ok, but indicated she didn't want to be in the hospital anymore and gave the location of their home. LPN 77 indicated to the caller that she would send someone down to get her. She called DON, the Administrator and the Activity Director. The Activity Director picked up the resident in the facility's van and brought her back to the facility. When she got back to the facility she looked her over good. She was alert and answered questions appropriately and just said she wanted to go home. The family was notified and she was place on 15 minute checks. QMA 72 indicated she was shocked that Resident C had left. To look at her you would not even had known she lived in a facility. She was an avid book reader and carried her purse everywhere. LPN 77 indicated the staff carried walkie talkies and when someone pushed the doorbell at the front door or at the employee entrance it would alert them. She thought the front door was locked around 8:00 p.m. and thought the kitchen staff locked the door to the employee entrance when they left.

During an interview with the Activity Director, on 6/8/22 at 2:33 p.m. she indicated she was just starting Bingo between 6:30 p.m. and 7:00 p.m. and LPN 77

notified her that Resident C was located at a house on the other side of the distribution facility. She used the facility van to pick her up. When she arrived at the house the resident was standing outside with a drink in her hand and two gentlemen was with her. She was not out of breath or in any distress. Resident C indicated to her it was nice outside and she was just taking a walk. The Activity Director also indicated the weather was beautiful that day and she felt that Resident C recognized her from activities. She had never known her to leave the facility before. She at times would get mixed up but liked to read and was in the library a lot. She had seen her out in the courtyards now that it was warmer out.

During an interview with the Regional Nurse Consultant, on 6/8/22 at 2:44 p.m., she indicated she had directed the DON via a text message to make sure some one did a skin assessment on the residents after the incidents and the DON indicated it was done. The night shift nurse in with him at some point in the documentation but not when he came back in. She was unable to locate either head to toe assessments for Resident C or Resident D. The front door camera they told her at times glitches and there was a camera on the employee entrance but they do not have

access to the cameras to watch things that had happened. She was not even sure how long they record. Some are for 7 days and some for 24 hours.

During an interview with the Administrator, on 6/8/22 at 3:12 p.m., she indicated she did not report Resident C's elopement at 6:00 p.m., because they new she would be discharged soon.

On 6/9/22 at 4:09 p.m., the Regional Nurse Consultant indicated their policy was that they followed IDOH guidelines for reporting elopements.

2. Resident D's clinical record was reviewed on 6/8/22 at 10:05 a.m. Diagnoses included, but was not limited to, diabetes and dementia.

His medications included, but was not limited to, donepezil (dementia) 23 mg (milligram) daily, memantine (dementia) 5 mg twice daily and metoprolol tartrate (blood pressure) 12.5 mg twice daily.

An undated pre-screening questionnaire indicated he sometimes forgot his medicine. He had a neurologist. He was very independent and very forgetful.

A SLUMS (Saint Louis University Mental Status) examination, dated 5/18/22, indicated he had a mild

neurocognitive disorder.

A service plan, dated 5/18/22, indicated he was oriented to person, place, time and situation. He ambulated independently and did not require assistance.

His nurses notes indicated, but was not limited to the following:

On 5/14/22 at 5:15 a.m., he was in the hallway and requested directions to the front doors. He stated he had a car parked out front that he wanted to check on and he had dropped his wife off at her sisters on the way to the facility and needed to get her and get home. He believed he was in a hotel. He was reoriented to time and place and reminded him that he did not have a vehicle at the facility and his spouse did not live at the facility with him. He was walked back to his room and was reoriented to his room. He appeared to be reoriented at that time and he stated getting old sucked, your memory just wasn't what it was when you were young. The writer would notify oncoming staff to monitor for increased confusion.

On 5/23/22 at 3:30 a.m., he came to the nurses station fully dressed with keys in his hand and wanted to know where the front door was because he needed to go pick his wife up

from his parents old house, he tried to call but she didn't answer and he was worried. The writer told him it was only 3:30 a.m. and she was probably sound asleep and we didn't want anyone leaving in the middle of the night. He stated he was in the military for years and he understood then he said I don't want to cause problems or get any one in trouble so he would just go back to his room and go to bed.

The clinical record lacked documentation of the elopement and a head to toe assessment.

On 5/23/22, late entry 9:00 a.m., he was in his room packing up his items and stated he had a house and couldn't afford this hotel. He was educated that the facility was his home now and not to worry about the cost, his son took care of everything. He stated maybe he was just confused and was in the military, his vitals were taken and no distress noted at that time. This nurse called son and the son came out to take him out for a while.

A late entry, on 5/23/22 at 11:00 a.m., he returned with son and was doing much better with no issues at that time.

On 5/23/22 at 1:30 p.m., he was in his room hanging up his clothes and kept saying he was

sorry for being confused. He was informed everything was ok and there was 24 hour nursing to help and be there for anything he needed. He verbalized understanding and there were no issues.

On 5/23/22 at 7:30 p.m., son was called due to resident's elopement yesterday and advised resident had to have a sitter or POA needed to come pick him up until management met to inform of instructions on how to proceed with resident's living arrangements.

A late entry, dated 5/23/22 at 8:00 p.m., his son came to pick him up and morning meds were given.

On 5/24/22 at 3:13 p.m., his son came to pick up meds. The resident was discharged from the facility to a skilled nursing facility.

During an interview with the Administrator, on 6/8/22 at 9:08 a.m., she indicated Resident D was new to the facility and family knew he had memory issues but it was worse than what they thought. He had forgotten that his wife after 30 years had divorced him and he was looking for his wife. He had come to the nurses station at 3:30 a.m. with keys in hand and indicated he had called his wife and she didn't answer and he

was going to go look for her. He indicated he was going back to bed and then the door bell rang and it was him on the porch. They did not have functional cameras in the facility to tell when he went out of the facility or came back in.

A current policy, titled "Resident Elopement/Wandering Risk," provided by the Administrator on 6/8/22 at 4:18 p.m., indicated the following: "...If it is determined that the resident may be at risk for elopement, immediate interventions should be put into place and the Resident/POA must agree to the interventions...Do not delay putting certain interventions in place if POA/Family is unavailable to meet...A Negotiated Risk Agreement is necessary for residents at risk for Elopement...."

This state tag relates to complaint IN00381022.

Based on observation, interview and record review the facility failed to prevent elopement for 2 of 2 residents reviewed for elopement. (Resident C and Resident D). This deficient practice resulted in Resident C leaving the facility and being found 0.5 mile from the facility.

Findings include:

1. Resident C's clinical record was reviewed on 6/8/22 10:52

a.m. Diagnoses included, but was not limited to, diabetes mellitus type II without complications, chronic depression, hypertension and osteoporosis.

Her medications included, but was not limited to, atenolol (blood pressure) 12.5 mg daily, fluoxetine (antidepressant) 10 mg (milligram) daily and melatonin (promote sleep) 3 mg daily.

A service plan, dated 3/23/22, indicated she was oriented to person and place. She had mild impairment: she had occasional disorientation to person, place, time or situation that did not interfere with functioning in familiar surroundings. May require some direction and reminding from others at times. She ambulated independently and did not require assistance.

Her nurses notes indicated, but was not limited to the following:

On 5/23/22 at approximately 4:30 a.m., writer had entered resident's room to give her her 5 a.m. pill, only to find her bed made and her MIA (Missing In Action). Writer immediately radioed staff to see if she had seen her. She indicated she had not. The lobby alarm started going off and they both went up front. The CNA went out first and didn't see anyone and then

the writer went out and didn't see anyone. No one had signed in that they were there at the facility (temperature taken). They started going from room to room looking for anyone missing. After checking rooms, they had not checked the kitchen or back hall. A resident had turned on her call light on for pain medication. Writer indicated to the CNA she would check the kitchen if she would check the back hall. Before writer got to the kitchen the CNA radioed that Resident C was outside the employee entrance. Writer and the CNA met in the hall between the dining room and kitchen. Resident C had books in her arm and was carrying a baggy with tupperware salt and pepper shakers. Resident C stated she was looking for her husband. Writer indicated to her that she had scared her when she couldn't find her. She heard the alarm sounding and asked if she did that. The writer gave her her medication and the CNA walked her back to her room and asked her not to leave anymore without telling them first.

The clinical record lacked a head to toe assessment.

On 5/23/22 at 6:20 p.m., the nurse received a call pertaining to the resident had walked over there [to a nearby residence] and the resident had stated she

was going home, they asked her to stay there until staff could retrieve her. Her POA, Executive Director and DON was notified. She returned with no apparent injuries. She understood at that time that she lived at the facility. POA was asked to sit with resident and was at the facility.

On 5/24/22 (no document time), late entry for 5/23/22, when Resident C returned to facility writer did a head to toe assessment, no areas were noted, no complaint of fall or pain. Her clothes appeared clean and she denied pain or discomfort.

Review of www.google.com/maps indicated the residence she was retrieved from was 0.5 miles south of the facility and it was a nine minute walk. There were no sidewalks located on either side of the road. The terrain was grass from the facility to the concrete driveway of the church, that was located next to the facility. Next to the church was a distribution facility and there was grass from the driveway of the church to the distribution facility driveway. There were three entrances into the distribution facility and between the entrances was grass, a drain culvert and a sloped drainage ditches located between the entrances. Located

next to the facility was the residence that Resident C was retrieved from. From the third entrance of the distribution facility and the driveway of the residence was grass. The driveway of the residence was stone and the house was approximately 100 feet or more off the road. The terrain from the facility to the residence where she was retrieved from was uneven, except for near or on the road.

Review of the website localconditions.com for historical weather, indicated on May 23, 2022 at 3:15 a.m. the temperature was 50 degrees Fahrenheit at 4:15 a.m. it was 49 degrees and at 3:55 p.m. it was 64 degrees, at 7:55 p.m. it was 64 degrees.

During an interview and an observation of the employee entrance with the Administrator, on 6/8/22 at 9:11 a.m., she indicated they had no other residents in the facility that were at risk for elopement. There were two closed doors with a push handle on the left door and both doors had rectangle windows in them, the service area and doors with windows to the outside that led to the employee parking lot was visible. When the door to the employee parking lot was opened an alarm did not sound. The CNA and nurse that worked

that night were checking the service hall and kitchen, and found Resident C standing outside the employee entrance door. She indicated the doors were locked at 9 p.m. to be able to get in but were unlocked to leave.

During an interview with the Regional Nurse Consultant and the Administrator, on 6/8/22 at 11:06 a.m., the Administrator indicated the cameras did work but she did not have access to them. They did complete 15 minute checks and an inservice for the elopements. The Regional Nurse Consultant indicated new doorbells were placed on the doors. They were looking at getting a new security system and lock everything down. Resident C did leave after she had walked outside at 4:30 a.m. and she also left at 6:20 p.m. and was found at the villas behind the facility that used to be part of the facility. They were not sure what door she went out of or how long she had been gone either time.

During an interview with LPN 77 and QMA 72, on 6/8/22 at 2:12 p.m., LPN 77 indicated they had just seen Resident C at dinner between 4:30 p.m. and 5:30 p.m. She had received a phone call between 6:30 p.m. and 7:00 p.m., the caller indicated that Resident C was at their home, she seemed to be ok, but

indicated she didn't want to be in the hospital anymore and gave the location of their home. LPN 77 indicated to the caller that she would send someone down to get her. She called DON, the Administrator and the Activity Director. The Activity Director picked up the resident in the facility's van and brought her back to the facility. When she got back to the facility she looked her over good. She was alert and answered questions appropriately and just said she wanted to go home. The family was notified and she was place on 15 minute checks. QMA 72 indicated she was shocked that Resident C had left. To look at her you would not even had known she lived in a facility. She was an avid book reader and carried her purse everywhere. LPN 77 indicated the staff carried walkie talkies and when someone pushed the doorbell at the front door or at the employee entrance it would alert them. She thought the front door was locked around 8:00 p.m. and thought the kitchen staff locked the door to the employee entrance when they left.

During an interview with the Activity Director, on 6/8/22 at 2:33 p.m. she indicated she was just starting Bingo between 6:30 p.m. and 7:00 p.m. and LPN 77 notified her that Resident C was located at a house on the other

side of the distribution facility. She used the facility van to pick her up. When she arrived at the house the resident was standing outside with a drink in her hand and two gentlemen was with her. She was not out of breath or in any distress. Resident C indicated to her it was nice outside and she was just taking a walk. The Activity Director also indicated the weather was beautiful that day and she felt that Resident C recognized her from activities. She had never known her to leave the facility before. She at times would get mixed up but liked to read and was in the library a lot. She had seen her out in the courtyards now that it was warmer out.

During an interview with the Regional Nurse Consultant, on 6/8/22 at 2:44 p.m., she indicated she had directed the DON via a text message to make sure some one did a skin assessment on the residents after the incidents and the DON indicated it was done. The night shift nurse in with him at some point in the documentation but not when he came back in. She was unable to locate either head to toe assessments for Resident C or Resident D. The front door camera they told her at times glitches and there was a camera on the employee entrance but they do not have access to the cameras to watch things that had happened. She

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On 6/9/22 at 4:09 p.m., the Regional Nurse Consultant indicated their policy was that they followed IDOH guidelines for reporting elopements.

2. Resident D's clinical record was reviewed on 6/8/22 at 10:05 a.m. Diagnoses included, but was not limited to, diabetes and dementia.

His medications included, but was not limited to, donepezil (dementia) 23 mg (milligram) daily, memantine (dementia) 5 mg twice daily and metoprolol tartrate (blood pressure) 12.5 mg twice daily.

An undated pre-screening questionnaire indicated he sometimes forgot his medicine. He had a neurologist. He was very independent and very forgetful.

A SLUMS (Saint Louis University Mental Status) examination, dated 5/18/22, indicated he had a mild neurocognitive disorder.

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On 5/23/22 at 3:30 a.m., he came to the nurses station fully dressed with keys in his hand and wanted to know where the front door was because he needed to go pick his wife up from his parents old house, he tried to call but she didn't

answer and he was worried. The writer told him it was only 3:30 a.m. and she was probably sound asleep and we didn't want anyone leaving in the middle of the night. He stated he was in the military for years and he understood then he said I don't want to cause problems or get any one in trouble so he would just go back to his room and go to bed.

The clinical record lacked documentation of the elopement and a head to toe assessment.

On 5/23/22, late entry 9:00 a.m., he was in his room packing up his items and stated he had a house and couldn't afford this hotel. He was educated that the facility was his home now and not to worry about the cost, his son took care of everything. He stated maybe he was just confused and was in the military, his vitals were taken and no distress noted at that time. This nurse called son and the son came out to take him out for a while.

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and there was 24 hour nursing to help and be there for anything he needed. He verbalized understanding and there were no issues.

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	bed and then the door bell rang and it was him on the porch. They did not have functional cameras in the facility to tell when he went out of the facility or came back in. A current policy, titled "Resident Elopement/Wandering Risk," provided by the Administrator on 6/8/22 at 4:18 p.m., indicated the following: "...If it is determined that the resident may be at risk for elopement, immediate interventions should be put into place and the Resident/POA must agree to the interventions...Do not delay putting certain interventions in place if POA/Family is unavailable to meet...A Negotiated Risk Agreement is necessary for residents at risk for Elopement...." This state tag relates to complaint IN00381022.			

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