

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/19/2024	
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF BLOOMINGTON MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3203 MOORES PIKE ROAD, BLOOMINGTON, , 47401					
(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 IN00442803. Complaint IN00442803 - State deficiencies related to the allegations are cited at R0052. Survey date: September 19, 2024 Facility number: 012706 Residential Census: 37 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed September 23, 2024.	R 0000	<i>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</i> R 052 410 IAC 16.2-5-1.2(v)(1-6)				

Residents' Rights -**Offense**

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

All staff in-serviced on community policy of Missing Resident/Wandering Resident. Nursing staff in-serviced on community policy of incident reports and following the elopement policy/High Risk Elopement Form. Nursing staff audited all medical records to ensure proper diagnosis, which is placed on assessments to ensure accuracy.

2. 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:

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			DON will continue to monitor/audit all resident assessments for all new admissions, any/all incidents, changes in condition and semi-annually to ensure on-going compliance. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur: ED and/or DON will in-service all staff immediately, upon new hire and continually thereafter every month for 3 months to ensure that all staff understand how to properly utilize the secured door alarm and the next steps to take if the egress is breached 4. 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:	
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ED and/or DON will in-service all nursing staff monthly for 6 months, and immediately upon any new hires on resident assessments for proper diagnosis for new admissions, any/all incidents, changes in condition, review facility policy for elopement, semi-annually to ensure on-going compliance. DON will report any concerns to the ED and will follow recommendations to ensure compliance.

5. By what date will the systemic changes be completed?

October 18,
2024

			ED and/or DON will in-service all nursing staff monthly for 6 months, and immediately upon any new hires on resident assessments for proper diagnosis for new admissions, any/all incidents, changes in condition, review facility policy for elopement, semi-annually to ensure on-going compliance. DON will report any concerns to the ED and will follow recommendations to ensure compliance. 5. By what date will the systemic changes be completed? October 18, 2024	
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;	R 0052	<i>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the</i>	10/18/2024

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OMB NO. 0938-0391

- (3) mental abuse;
- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on observation, interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 3 residents reviewed for elopement. A resident with an assessed behavior of wandering and exit seeking was not provided supervision to prevent an elopement which resulted in the resident exiting the facility and wandering over two city blocks from the facility.
(Resident B)

Findings include:

On 9/19/24 at 12:00 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, mild cognitive impairment and depression.

The Initial Assessment at Admission Form, completed on 7/31/24, for Resident B indicated, "... Elopement Risk Factors: Sleep disturbances, yes, intermittent confusion, yes, disorientated to time and place, yes, history or current diagnosis of depression, yes, highly mobile, likes to walk, yes. High-Risk Factors: wanders,

residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

**R 052 410
IAC 16.2-5-1.2(v)(1-6)
Residents' Rights -**

Offense

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

All staff in-serviced on

yes, sundowning, yes, inappropriate expressions or behaviors present, yes ..."
Resident B was given a score of 16 plus, which indicated the resident was a high risk for elopement.

A review of the Elopement Root Cause Analysis form, dated 9/7/24, for Resident B indicated the following: On 9/7/24 at 5:50 p.m., resident pushed on the front door, initiating alarm system. When CNA 3 heard alarm, she immediately went to front entrance door. After alerting staff, she began searching parameter with the dietary aide. The resident had finished evening meal and was intent on returning to her former home in (former city name). She believes she works here 10:00 a.m. to 6:00 p.m. Search was initiated and followed according to policy. The police were notified and the resident was returned unharmed to the facility. The resident was found one block east sitting on a front porch swing of a neighbors house.

During an interview on 9/19/24 at 12:05 p.m., the Director of Nursing (DON) indicated Resident B was admitted to the facility and was assessed as a high elopement risk. On 9/7/24 at approximately 5:35 p.m., CNA 1, CNA 2, CNA 3, and LPN 1 were on duty. CNA 1 and CNA

community policy of Missing Resident/Wandering Resident. Nursing staff in-serviced on community policy of incident reports and following the elopement policy/High Risk Elopement Form. Nursing staff audited all medical records to ensure proper diagnosis, which is placed on assessments to ensure accuracy.

2. 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:

DON will continue to monitor/audit all resident assessments for all new admissions, any/all incidents, changes in condition and semi-annually to ensure on-going compliance.

3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:

ED

2 were in the dining room helping residents eat because it was dinner time. CNA 3 was helping a resident in his room. LPN 1 was also helping the residents eat in the dining room. The DON had just left for the day but received a call a few minutes later from the Administrator of the elopement. The DON headed back to the facility and notified 911. The CNA's started looking around the facility and someone from dietary began checking the perimeter outside. While on the phone with 911, the officer told her to hang on because he had another call about a resident being seen on the main road near where the facility was located. Another call came in to 911 at that time from a neighbor of the facility that a woman was sitting in a rocker on her front porch. Resident B was gone from the building approximately 61 minutes, it was about 76 degrees outside and the resident had gone about 2 city blocks. The DON's understanding of the incident was 3 residents were at the locked door that leads outside to the lobby. The door had a mechanism that after 15 seconds of holding the bar where it will unlock for fire purposes. The residents had held the bar down and opened the door. CNA 3 ran down the hall and found the residents. When CNA 3 went to do a head

and/or DON will in-service all staff immediately, upon new hire and continually thereafter every month for 3 months to ensure that all staff understand how to properly utilize the secured door alarm and the next steps to take if the egress is breached

4. 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 elopement policy will be reviewed with all staff monthly (at the all-staff meeting.) All new hires will be trained on the policy as a part of their orientation.

Elopement drills will be conducted by the ED or DON weekly for 1 month and monthly thereafter.

5. By what date will the systemic changes be completed?

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count, Resident B was missing. The facility initiated the lost resident protocol and the police ended up bringing Resident B back.

During an interview on 9/19/24 at 12:50 p.m., LPN 1 indicated on 9/7/24 she was in the dining room assisting residents to eat along with CNA 1 and CNA 2. It was dinner time at approximately 5:30 p.m., when she heard the alarm go off and immediately ran to the front. The door alarm went off when someone made an attempt to get out. After 15 seconds of pushing on the bar the door will open. When she arrived the door was open and one of the residents was outside the unit in the lobby. She brought the resident back in, took a head count and Resident B was missing from the group. They immediately started searching for the resident.

During an interview on 9/19/24 at 1:11 p.m., with CNA 1 she indicated she was in the dining room assisting residents to eat when she saw everyone running around but did not hear the alarm. She stayed with the residents in the dining room and did not participate in the search. It was around dinner time.

During a tour of the front door and lobby area on 9/19/24 at 1:15 p.m., with the DON, the

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front door was observed to have a bar in the middle of the door. The DON held the bar for approximately 15 seconds. The alarm did sound and the door opened after the 15 second mark. There was a sign on the door that indicated to push for alarm to sound.

During an interview on 9/19/24 at 1:20 p.m., CNA 3 indicated there were 2 CNA's and 1 LPN in the dining room assisting residents to eat. She was down the hall helping a private caregiver with a male resident in his room. She heard the alarm go off but was unable to immediately go down the hall because she was in the middle of helping the male resident. She assumed the other staff members would go and help. When she finished with the male resident she went down the hall to the front door because the alarm was still going off. She asked CNA 1, CNA 2, and LPN 1 why the alarm was going off and LPN 1 told her a group of residents had opened the door but they were all back inside. LPN 1 and the two CNA's were still assisting residents to eat. LPN 1 indicated she thought they had reset the alarm. CNA 3 informed CNA 1, CNA 2, and LPN 1 that the alarm was still sounding. CNA 3 went back to the door and had begun a head count of the residents. She then realized Resident B was not in

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the area. She initiated a search and informed the other staff members to search. They searched the entire building but two of the staff members including herself were derailed because they found another resident had fallen. After they were finished assisting the resident who had fallen they resumed searching. CNA 3 went into the parking lot and the oncoming shift were sitting in their cars. She asked them to please come to work early and start looking because the needed all hands on deck. CNA 3 got into her car and drove around but did not see the resident. When she arrived back at the facility the police had arrived and returned Resident B unharmed.

On 9/19/24 at 1:21 p.m., the DON provided the policy, "Elopement Risk Policy and Procedures" with an updated date of 3/24/22, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " ... If a resident is determined to be at risk for elopement, a plan will be developed and implemented and will be reviewed with care team to include ... interventions to minimize the potential for resident elopement ..."

This State tag relates to Complaint IN00442803.

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Based on observation, interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 3 residents reviewed for elopement. A resident with an assessed behavior of wandering and exit seeking was not provided supervision to prevent an elopement which resulted in the resident exiting the facility and wandering over two city blocks from the facility.
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Resident B was given a score of 16 plus, which indicated the resident was a high risk for elopement.

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minutes later from the Administrator of the elopement. The DON headed back to the facility and notified 911. The CNA's started looking around the facility and someone from dietary began checking the perimeter outside. While on the phone with 911, the officer told her to hang on because he had another call about a resident being seen on the main road near where the facility was located. Another call came in to 911 at that time from a neighbor of the facility that a woman was sitting in a rocker on her front porch. Resident B was gone from the building approximately 61 minutes, it was about 76 degrees outside and the resident had gone about 2 city blocks. The DON's understanding of the incident was 3 residents were at the locked door that leads outside to the lobby. The door had a mechanism that after 15 seconds of holding the bar where it will unlock for fire purposes. The residents had held the bar down and opened the door. CNA 3 ran down the hall and found the residents. When CNA 3 went to do a head count, Resident B was missing. The facility initiated the lost resident protocol and the police ended up bringing Resident B back.

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This State tag relates to Complaint IN00442803.

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