STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW BROOK SENIOR LIVING	11011 VILLAGE SQUARE LANE, FISHERS, , 46038

(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 IN00384914 Complaint IN00384914 - Substantiated. State Residential Finding related to the allegations are cited at R0052 and R0091. Survey date: July 20, 2022 Facility number: 013163 Residential Census: 81 These State Residential Finding are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 22, 2022	R 0000	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 any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	***What corrective actions will be accomplished for those residents found to have been affected by the finding:***	08/05/2022

	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident's right to be free of neglect related to staff not following the facility's policies and procedures for interventions upon the alarming of the secured doors of the Memory Care Unit (MCU) for a cognitively impaired resident, resulting in 1 of 3 residents reviewed for elopement being able to exit the building unaccompanied and being out of sight of the facility staff for a minimum of 10 minutes and up to 20 or more minutes. (Resident B) Findings include: On 7-20-22 at 1:30 p.m., the Executive Director (ED) provided a copy of an incident report in which it indicated on 7-8-22 at 4:01 a.m., Resident B had left the facility's memory care unit by pushing on an alarmed security door with an emergency egress function. It indicated the staff responded to the alarm, initiated a search and		All Memory Care Residents have the potential to be affected due to disease process. No Memory Care Resident were found to be affected. ***How will you identify other residents having the potential to be*** ***affected by the same finding and what corrective action will be taken:*** All Memory Care Residents have the potential to be affected. Elopement Risk of all Memory Care Residents completed on 8/3/22 by Memory Care Director. Elopement Risk will be reviewed by Memory Care Director and Executive Director weekly X 3 months, bi-weekly X 3 months and monthly thereafter. (Elopement Risk Attachment A)	

	head count and was able to return the resident to the MCU without injury. A follow-up report, dated 7-13-22, indicated Resident B had displayed no further exit-seeking behaviors, nor any psychosocial distress and the staff had received education on this topic. The initial report was received by the Indiana Department of Health's Long-Term Care Division on 7-8-22 at 4:00 p.m. In a written statement from Residential Aide 4, dated 7-8-22, he indicated, "Around 4am I noticed the alarm in memory care going off. I check my shift app to get [name of QMA 5] number. And called him to let him no [sic] alarm was going off and he come down to see what was going on." In a written statement from QMA 5, he indicated: "Around 4am, the agency aid working on memory care called the facility phone I was carrying and stated that there is an alarm going off. The aid stated he did not know why the alarm was going off. I then hurried down to memory care and disabled the alarm. I began to do a head count of the residents on the unit. While executing the count I realized there was a resident missing so I began to search the memory care while directing other staff to begin searching the other area of the building. I did not locate		***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 will be in-serviced on Missing Resident -Elopement Policy & Procedure and Memory Care Secure Door. Contract Nursing staff will complete and sign off on MC orientation before start of shift. Executive Director or Designee will audit signed documentation daily this will be on-going. (Attachments B). Contract Nursing Assistant Orientation, Missing Resident - Elopement, Alarm Memory Care/Residential Care and Memory Care Secured Doors ***How the corrective action(s) will be monitored to ensure the finding will not recur:***	

	the resident on MC and quickly called the DON [Director of Nursing], and charge nurse who notified the ED. I continued my search throughout the building and instructed the agency RA [Resident Assistant] to remain in place on memory care and continue searching there as well. I was doing a perimeter search of the building when DON, charge nurse and ED all arrived at the building about 15-25 min from first notification. We quickly located the residents [sic] and redirected him back inside the community and then back to the M/C unit ..." On 7-20-22 at 1:20 p.m., the ED provided a copy of a document entitled, "Verification of Incident Investigation/Administrative Summary." This document indicated Resident B exited the memory care unit on 7-8-2022 at 4:10 a.m., with the egress alarm sounding. It clarified the facility "staff responded, searched direct perimeter, completed head count on MC, ED & DON notified. At approximately 4:10 a.m., resident left MC doors main entrance. Walked through lobby and out the front door. Egress alarm sounding. Staff responded by doing head count, searched MC and AL [assisted living portion of building] and direct perimeter of the community. ED and DON notified, came to building to		Executive Director or Designee will interview random sampling of staff on Missing Resident – Elopement Policy & Procedure and Memory Care Secure Door: 5 staff Weekly x4 weeks 5 staff Biweekly x4weeks 5 staff Monthly x4months (Attachment C)	

assist. Resident located on the exterior of the community..."

In an interview with the ED on 7-20-22 at 12:20 p.m., she indicated Resident B had pushed on the entrance door to the memory care unit long enough that it unlocked and he left the memory care unit, walked down the hall and out the front door. He was located several minutes later on the perimeter of the premises.

In an interview with the ED on 7-20-22 at 1:55 p.m., she indicated after Resident B's elopement, "We did make a few changes with our night shift staffing patterns. We normally have 3 staff in the building. We had been having 1 person on memory care and 2 for AL. When that happened, we made a change to having 2 staff on memory care and 1 person on AL with the ability to float back and forth. This really seems to be working well and we are still staffing like that."

In an interview with the DON on 7-20-22 at 11:45 a.m., she indicated Resident B had not displayed any exit seeking behaviors prior to or after the elopement of 7-8-22.

In review of Resident B's clinical record on 7-20-22 at 11:02 a.m., it indicated his diagnoses included, but were not limited to,

dementia and peripheral neuropathy. It indicated he had been admitted to the facility's MCU less than 2 months ago. His initial Service Plan, dated 6-9-22, indicated he has moderate-level dementia, requiring the use of a memory care unit, he is independently mobile without the use of any assistive devices, has difficulty with communication requiring unspecified assistance, displayed no behaviors, does wander intrusively, but is easily re-directable, is alert and cooperative, answers questions inappropriately, has a passive mood and has clear speech, but is unable to comprehend.

In an observation of Resident B on 7-20-22 at 1:15 p.m., he was located in his room and appeared to be in no distress. His speech was clear, but very slow to respond to general questions, such as, "How are you?" He did not appear to recall his elopement of 12 days prior.

The ED provided documentation on 7-20-22 at 1:20 p.m., of education provided to staff on 7-8-22, entitled, "Memory Care Door Alarm." The education included a review of the facility's policy and procedure entitled, "Alarms Memory Care/Residential Care."

On 7-20-22 at 1:20 p.m., the ED

	provided a copy of the facility's policy entitled, "Alarms Memory Care/Residential Care." This policy had an origination date of June, 2014, with no revisions identified. This policy indicated, "The Memory Care community/facility has alarmed doors leading to the outside of the building to provide a safe environment for our residents. The tendency to wander inside and outside the community is a common behavior by residents with dementia and Alzheimer's disease." It indicated alarm system are to be activated at all times; when an alarm sounds, staff are to "respond every time an alarm sounds." Staff are to determine which door alarm has been activated and reset the alarm. "A staff member must go to the door(s) that have been opened to investigate the situation. When arriving at the door, the staff member must redirect the resident(s) back inside the community. If a resident has eloped, it is also important to walk outside to make certain all resident who might have exited are escorted back inside the community. During the time the situation at the door is being investigated, another staff member should initiate a head count of all residents. A head count of all residents is essential to make certain that every resident that may have exited is inside the community. If a resident is still			

	determined to be missing, begin the procedures for the 'Missing Resident Plan' in the Disaster/Evacuation Section of the manual." This Residential tag relates to Complaint IN00384914. 5.1-2(v)(5) Based on observation, interview and record review, the facility failed to ensure a resident's right to be free of neglect related to staff not following the facility's policies and procedures for interventions upon the alarming of the secured doors of the Memory Care Unit (MCU) for a cognitively impaired resident, resulting in 1 of 3 residents reviewed for elopement being able to exit the building unaccompanied and being out of sight of the facility staff for a minimum of 10 minutes and up to 20 or more minutes. (Resident B) Findings include: On 7-20-22 at 1:30 p.m., the Executive Director (ED) provided a copy of an incident report in which it indicated on 7-8-22 at 4:01 a.m., Resident B had left the facility's memory care unit by pushing on an alarmed security door with an emergency egress function. It indicated the staff responded to the alarm, initiated a search and head count and was able to			

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	neuropathy. It indicated he had been admitted to the facility's MCU less than 2 months ago. His initial Service Plan, dated 6-9-22, indicated he has moderate-level dementia, requiring the use of a memory care unit, he is independently mobile without the use of any assistive devices, has difficulty with communication requiring unspecified assistance, displayed no behaviors, does wander intrusively, but is easily re-directable, is alert and cooperative, answers questions inappropriately, has a passive mood and has clear speech, but is unable to comprehend. In an observation of Resident B on 7-20-22 at 1:15 p.m., he was located in his room and appeared to be in no distress. His speech was clear, but very slow to respond to general questions, such as, "How are you?" He did not appear to recall his elopement of 12 days prior. The ED provided documentation on 7-20-22 at 1:20 p.m., of education provided to staff on 7-8-22, entitled, "Memory Care Door Alarm." The education included a review of the facility's policy and procedure entitled, "Alarms Memory Care/Residential Care." On 7-20-22 at 1:20 p.m., the ED provided a copy of the facility's			

	policy entitled, "Alarms Memory Care/Residential Care." This policy had an origination date of June, 2014, with no revisions identified. This policy indicated, "The Memory Care community/facility has alarmed doors leading to the outside of the building to provide a safe environment for our residents. The tendency to wander inside and outside the community is a common behavior by residents with dementia and Alzheimer's disease." It indicated alarm system are to be activated at all times; when an alarm sounds, staff are to "respond every time an alarm sounds." Staff are to determine which door alarm has been activated and reset the alarm. "A staff member must go to the door(s) that have been opened to investigate the situation. When arriving at the door, the staff member must redirect the resident(s) back inside the community. If a resident has eloped, it is also important to walk outside to make certain all resident who might have exited are escorted back inside the community. During the time the situation at the door is being investigated, another staff member should initiate a head count of all residents. A head count of all residents is essential to make certain that every resident that may have exited is inside the community. If a resident is still determined to be missing, begin			

	the procedures for the 'Missing Resident Plan' in the Disaster/Evacuation Section of the manual." This Residential tag relates to Complaint IN00384914. 5.1-2(v)(5)			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to follow their written policies and procedures related to supervision of residents that have the potential for elopement from a memory care unit (MCU) for 1 of 3 residents reviewed for elopement, resulting in the delay in locating the resident.	R 0091	***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** All Memory Care Residents have the potential to be affected due to disease process. No Memory Care Resident were found to be affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All Memory Care Residents have the potential to be affected. Elopement Risk of all Memory Care Residents completed on 8/3/22 by Memory Care Director. Elopement Risk will be reviewed by Memory Care Director and Executive Director weekly X 3 months, bi-weekly X 3 months and	08/05/2022

(Resident B)

Findings include:

On 7-20-22 at 1:30 p.m., the Executive Director (ED) provided a copy of an incident report in which it indicated on 7-8-22 at 4:01 a.m., Resident B had left the facility's memory care unit by pushing on an alarmed security door with an emergency egress function. It indicated the staff responded to the alarm, initiated a search and head count and was able to return the resident to the MCU without injury. A follow-up report, dated 7-13-22, indicated Resident B had displayed no further exit-seeking behaviors, nor any psychosocial distress and the staff had received education on this topic. The initial report was received by the Indiana Department of Health's Long-Term Care Division on 7-8-22 at 4:00 p.m.

In a written statement from Residential Aide 4, dated 7-8-22, he indicated, "Around 4am I noticed the alarm in memory care going off. I check my shift app to get [name of QMA 5] number. And called him to let him no [sic] alarm was going off and he come down to see what was going on."

In a written statement from QMA 5, he indicated: "Around 4am, the agency aid working on

monthly thereafter. (Elopement Risk Attachment A)

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 will be in-serviced on Missing Resident -Elopement Policy & Procedure and Memory Care Secure Door. Contract Nursing staff will complete and sign off on MC orientation before start of shift. Executive Director or Designee will audit signed documentation daily this will be on-going. (Attachments B). Contract Nursing Assistant Orientation, Missing Resident - Elopement, Alarm Memory Care/Residential Care and Memory Care Secured Doors

How the corrective action(s) will be monitored to ensure the finding will not recur:

Executive Director or Designee will interview random sampling of staff on Missing Resident – Elopement Policy & Procedure and Memory Care Secure Door:

5 staff Weekly x4 weeks5 staff Biweekly x4weeks5 staff Monthly x4months(Attachment C)

memory care called the facility phone I was carrying and stated that there is an alarm going off. The aid stated he did not know why the alarm was going off. I then hurried down to memory care and disabled the alarm. I began to do a head count of the residents on the unit. While executing the count I realized there was a resident missing so I began to search the memory care while directing other staff to begin searching the other area of the building. I did not locate the resident on MC and quickly called the DON [Director of Nursing], and charge nurse who notified the ED. I continued my search throughout the building and instructed the agency RA [Resident Assistant] to remain in place on memory care and continue searching there as well. I was doing a perimeter search of the building when DON, charge nurse and ED all arrived at the building about 15-25 min from first notification. We quickly located the residents [sic] and redirected him back inside the community and then back to the M/C unit ..."

On 7-20-22 at 1:20 p.m., the ED provided a copy of a document entitled, "Verification of Incident Investigation/Administrative Summary." This document indicated Resident B exited the memory care unit on 7-8-2022 at 4:10 a.m., with the egress alarm sounding. It clarified the

facility "staff responded, searched direct perimeter, completed head count on MC, ED & DON notified. At approximately 4:10 a.m., resident left MC doors main entrance. Walked through lobby and out the front door. Egress alarm sounding. Staff responded by doing head count, searched MC and AL [assisted living portion of building] and direct perimeter of the community. ED and DON notified, came to building to assist. Resident located on the exterior of the community..."

In an interview with the ED on 7-20-22 at 12:20 p.m., she indicated Resident B had pushed on the entrance door to the memory care unit long enough that it unlocked and he left the memory care unit, walked down the hall and out the front door. He was located several minutes later on the perimeter of the premises.

In review of Resident B's clinical record on 7-20-22 at 11:02 a.m., it indicated his diagnoses included, but were not limited to, dementia and peripheral neuropathy. It indicated he had been admitted to the facility's MCU less than 2 months ago. His initial Service Plan, dated 6-9-22, indicated he has moderate-level dementia, requiring the use of a memory care unit, he is independently

mobile without the use of any assistive devices, has difficulty with communication requiring unspecified assistance, displayed no behaviors, does wander intrusively, but is easily re-directable, is alert and cooperative, answers questions inappropriately, has a passive mood and has clear speech, but is unable to comprehend.

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determine which door alarm has been activated and reset the alarm. "A staff member must go to the door(s) that have been opened to investigate the situation. When arriving at the door, the staff member must redirect the resident(s) back inside the community. If a resident has eloped, it is also important to walk outside to make certain all resident who might have exited are escorted back inside the community. During the time the situation at the door is being investigated, another staff member should initiate a head count of all residents. A head count of all residents is essential to make certain that every resident that may have exited is inside the community. If a resident is still determined to be missing, begin the procedures for the 'Missing Resident Plan' in the Disaster/Evacuation Section of the manual."

This Residential tag relates to Complaint IN00384914.

5.1-3(h)(1)

5.1-3(h)(2)

Based on interview and record review, the facility failed to follow their written policies and procedures related to supervision of residents that have the potential for elopement from a memory care unit (MCU)

for 1 of 3 residents reviewed for elopement, resulting in the delay in locating the resident. (Resident B)

Findings include:

On 7-20-22 at 1:30 p.m., the Executive Director (ED) provided a copy of an incident report in which it indicated on 7-8-22 at 4:01 a.m., Resident B had left the facility's memory care unit by pushing on an alarmed security door with an emergency egress function. It indicated the staff responded to the alarm, initiated a search and head count and was able to return the resident to the MCU without injury. A follow-up report, dated 7-13-22, indicated Resident B had displayed no further exit-seeking behaviors, nor any psychosocial distress and the staff had received education on this topic. The initial report was received by the Indiana Department of Health's Long-Term Care Division on 7-8-22 at 4:00 p.m.

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moderate-level dementia, requiring the use of a memory care unit, he is independently mobile without the use of any assistive devices, has difficulty with communication requiring unspecified assistance, displayed no behaviors, does wander intrusively, but is easily re-directable, is alert and cooperative, answers questions inappropriately, has a passive mood and has clear speech, but is unable to comprehend.

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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	TITLE	(X6) DATE

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		