STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF EDISON LAKES	1025 PARK PLACE, MISHAWAKA, , 46545

(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 IN00385169 and IN00383249. Complaint IN00385169 - Substantiated. State Residential Findings related to the allegations are cited at R0052 and R0090. Complaint IN00383249- Unsubstantiated due to lack of evidence. Survey dates: July 13 & 14, 2022 Facility number: 013331 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/19/22.	R 0000		
R 0052	Residents' Rights - Offense	R 0052	R 052 Residents’	07/27/2022

	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, record review and interview, the facility failed to ensure residents were free from neglect, related to no additional interventions, besides a wanderguard, to prevent 3 of 3 residents, with exit seeking behaviors and cognitively impaired, from exiting the facility unattended, resulting in one resident not being located for over 72 hours. (Resident B, Resident D and Resident E) Findings include:		Rights-Offense 1. The corrective action that was put in place for the facility failing to ensure residents were free from neglect, related to no additional interventions, besides a wanderguard, to prevent residents, with exit seeking behaviors and cognitively impaired, from exiting the facility unattended, resulting in one resident not being located for over 72 hours, is that an in-service for all staff was given by the Director of Wellness on July 27, 2022, instructing staff, upon the alarm alerting staff that a resident wearing a wanderguard has opened an exterior door, the staff must immediately start their search for the resident, outside the door that is alarming. The search must also simultaneously consist of staff searching indoors for that resident as well. The Director of Wellness or designee will continue to meet with the staff monthly to discuss any concerns and proper procedures and current policies. An all-staff in-service is scheduled for August 25, 2022, to discuss residents that have tendencies to wander and what	

	1. On 7/13/22 at 10:11 A.M., a review of the clinical record for Resident B was conducted. The resident was admitted on 7/5/22. The resident's diagnoses included, but were not limited to: dementia, major depressive disorder, osteoarthritis of knee and diabetic. The resident was 83 years old. A Prospective Resident Health Assessment form, dated 6/28/22, indicated the resident had wandering behaviors and searched in her apartment for things, she had currently been falling 2 times a week and had hallucinations-seeing people in her room. An Elopement Risk Evaluation, dated 6/28/22, indicated the resident's score was 12. A score between 6-15 indicated the resident was a moderate risk for an elopement. The form indicated the resident had "high risk" factors which included the following: the resident was disoriented to time and place and had intermittent confusion. The form stated "...NOTE: If any of the HIGH RISK FACTORS are present, secured neighborhood is recommended ...." A MMSE (Mini-Mental State Examination), undated, indicated the resident's score was 8 out of 30, with a score		causes those wandering behaviors and the importance of notifying the Director of Wellness or designee if a resident begins to have wandering behaviors. If a resident starts to display wandering tendencies the Director of Wellness or designee will put frequent checks in place to monitor the wandering resident to ensure his/her safety. 2. 2. To ensure immediate compliance with the state regulation, all three families whose resident was wearing a wanderguard, were contacted by the Administrator and asked to have a private duty caretaker sit with them as the facility was terminating the wanderguard system that was in place, by August 19, 2022. All new admissions will be monitored for wandering behaviors for the first 7 days after admission. If a new admission should have wandering tendencies the Director of Wellness or designee should be notified immediately. During the all-staff meetings twice daily, the Director of Wellness or designee will discuss all new admissions and anyone with wandering tendencies to	

	less than 9 stating severe cognitive impairment. A form titled, "Individualized Service Plan", dated 6/28/22, indicated the resident needed a wanderguard (an alert system to inform staff if a resident was in an off limit area). The wanderguard would be placed on the resident for her safety, but the plan indicated the resident would "need guidance on where to go and sit". A Progress Note, dated 7/5/22 at 11:00 A.M., indicated Resident B was admitted to apartment 219, from home brought to community by her sister. A Progress Note, dated 7/6/22 at 7:45 P.M. indicated "...Res. [resident] in apartment, refusing to allow CNA to help her into pajamas, wants to wear them over her clothing. Res. [resident] attempting to verbalize but staff unable to make any sense of what she is trying to say at times, told CNA she needed to wear clothing under her pajamas because she is 'undercover'. Res [resident] holding a [name of facility] calendar, saying she was looking for phone numbers of people to call, using her TV remote as a phone. Refuses to let CNA check her to see if she is wet...."		formulate an immediate plan of care. 3. 3.The facility issued a 30-day written discharge notice to these three residents who were using the wanderguard and communicated to their families that a secure memory care unit was necessary for the resident's safety. Administrator contacted the local and state ombudsman regarding the 30-day move out notices. 4. 4.Director of Wellness or designee will incorporate into the preadmission assessment, parameters that if a potential prospect scores lower than 15 on the mini mental examination, that the Director of Wellness or designee gives to the prospect, then they will not qualify for admission to Cedarhurst of Edison Lakes. If the prospect has a diagnosis of dementia upon preadmission assessment, the Director of Wellness or designee will notify the prospect's physician of the mini mental score and ensure that the physician is aware that Cedarhurst of Edison Lakes does not have	

	A Progress Note, dated 7/7/22 at 10:00 P.M., documented by LPN 2 indicated "...Res [resident] wandering throughout the West 2nd floor hall for the past several hours, set off a "loiter alert" near the 2nd floor northwest stairwell several times since 7pm. Observed by other residents trying to open mechanical room and storage room doors. Noted to be carrying a large vase of flowers around. Entered the apartment of another res while this writer was passing hs[bedtime] meds [medications]. Returned her to her room. Res [resident] returned to the area near the upstairs west elevator, seated in a chair. Hs [bedtime] meds [medications] taken without difficulty...." A Progress Note, dated 7/8/22 at 3:15 A.M., documented by LPN 2 indicated the following; "...Summoned to apt. [apartment] #222 by resident of apt. [apartment] #222 at approx. [approximately] 12:30 am, when CNA responded he found [name of Resident B], who lives in apt. #219, in his apt. She had urinated in his recliner, and then removed her wet brief and tossed it on the floor, and then went and sat down on his couch, naked from the waist down. She refused to leave apt. #222, saying that it was her apt. [apartment]and staff should leave her alone. CNA called this		a secure memory care unit. These protocols will begin July 25, 2022. 5. 5.Two of the three residents that were using the wanderguard system, have since discharged from the facility. The last remaining resident of the three that were wearing a wanderguard, is scheduled to be discharged by August 19th. Once that resident has found a secure memory care setting, the wanderguard system will no longer be a system that is used at Cedarhurst of Edison Lakes. If that resident remains at the facility beyond August 19, 2022, the family will provide a caregiver to sit with the resident 24/7 to ensure her safety.	

	nurse to the apt. [apartment] where I found [name of Resident B] sitting on the couch, naked from the waist down. Assistant Wellness Director [name of LPN 5] was contacted and she advised that I call her sister/POA [name of sister] to come to the facility and remove her sister from apt. #222. There was no answer and a voicemail was left. [Name of LPN 5] then gave the okay to attempt to contact her nephew [name of nephew]. No answer. Staff was directed to come up with creative ways to get her to exit the apt. [apartment], to no avail. She refused offers of something to drink or a treat. She just kept repeatedly asking, sometimes yelling, at staff to leave her alone so she could go to sleep. Staff stayed with her in apt. [apartment] #222 in order to keep both her and the occupant res [resident] safe. Two staff stayed in the apt. [apartment] and attempted to reason with her. [Name of Resident B] became combative, trying to hit CNA and myself several times. She couldn't understand why staff would not leave and let her go to sleep on the couch. At approx. [approximately] 2:45 am [name of Resident B] said she had to urinate, and that she was going to urinate "over there" pointing to the corner of apt. [apartment] 222's living room. When her path was blocked by staff, she walked toward the			

	apt's. [apartments] open door, stopped for a few minutes in the doorway, and then exited the apt. [apartment] She walked north down the hallway, trying to open each apt. [apartment] door as she went, and urinating in several places on the carpet throughout the hall. When she reached the end of the hall she turned around, and made her way back to her own apt. [apartment] #219. The door to her apt. [apartment] was open, and she went in, locking her door behind her...." A Progress Note, dated 7/8/22 at 10:39 A.M., indicated the physician was contacted, by the Assistant Wellness Director/LPN 5 to report the resident's blood pressure and the resident was complaining of right hip pain. The Note indicated the resident was having difficulty walking. A form titled, "Psychiatry Initial Consult", dated 7/8/22, indicated the resident was seen in her room using a video interface platform. The resident was pleasant during the assessment and indicated she was adjusting to her new surroundings. The staff reported, the resident was up wandering at night, having exit seeking behaviors, going into others' apartments and urinating in inappropriate places, which was likely a combination of new surroundings and BPSD			

	(Behavioral and Psychological Symptoms of Dementia.) The form indicated nursing was to monitor and document any new or worsening moods and/or behaviors. A Progress Note, dated 7/8/22 at 1:27 P.M., documented by the Assistant Director of Wellness (ADOW) indicated the resident had a telehealth visit with the psychiatric Nurse Practitioner (NP). The NP wrote new orders for Resident to start Zoloft (anti-depressant) 50 milligrams (mg), 1 tablet daily, Trazadone (sedating anti-depressant) 50 mg, 1 tablet at bedtime, and Rivastigmine (treatment for Alzheimer's Disease) 1.5 mg 1 tablet, at bedtime. The resident's sister was notified of the additional medications. A Progress Note, dated 7/10/22 at 6:56 A.M., documented by Qualified Medication Assistant (QMA) 6 indicated "...Up all night. Opening residents doors. Refused evening meds [medications]. Aggressive towards staff, stated she was calling police. Redirected put on 15 min [minute] checks, then 30 mins. [minutes]. Set off elopement alarm. Did not sleep till 5am...." A Progress Noted, dated 7/10/22 at 6:34 P.M., documented by QMA 4			

	indicated "...Resident pulled fire alarm, resident also is taking things off of other residents doors...." A Progress Note, dated 7/11/22 at 6:00 P.M., documented by the Director of Wellness (DOW) indicated "...Resident walked out of the building and wanderguard was set off at approx 2:05pm. Staff immediately responded and did not see resident when they looked out the exit. Resident was seen by postal worker about that time walking east on [a local street]. She had on maroon short sleeved shirt and tan pants and pink slippers. DON notified. ED [Executive Director] notified. Sister [name of sister] notified. [Name of city] police notified. Search ensued with all staff assisting in the search or at communication points through out the neighborhood. Search by staff in cars and on foot. Police and staff also searched at resident previous address. Resident has not been found. Family here and actively involved in search including sister [name of sister] and nephew [name of nephew]. Called and left message for [name of physician]. Silver Alert posted by police. Drone search completed. Reporting ELOPEMENT...." An Incident Report #107, dated 7/11/22, indicated at 1:45 P.M.,			

	a wanderguard alarm alerted staff to a stairwell on the westside of the building. Within 4 minutes nursing staff went to the stairwell and did not see anyone around the stairwell or outside. They continued to check all the residents, with a wanderguard and noted resident in room 219 was missing. The Report indicated all the apartments and rooms in the building were searched. Nursing noted resident was seen outside in the front circle area. The adjacent properties were immediately searched and the resident was not located. The Executive Director was out of state and was notified of the situation. The resident's sister /POA was notified and she immediately came to the facility to help in the search effort. The local police were notified immediately and responded in the search. After 2 hours the police initiated a "Silver Alert", media alert and started using a drone to search the area. The resident's physician was notified of the situation. The preventative measures in place were a wanderguard and psychiatric services, which had been initiated on 7/8/22. A request for the complete investigation was requested and a timeline was received. During an interview, on 7/13/22 at 12:02 P.M., the Activity Coordinator described the			

	events, on 7/11/22 just prior to 2:00 P.M. The Activity Coordinator indicated she observed Resident B outside, on the far center, of the circle driveway, and the resident was wearing pink slippers. She said the resident was walking slowly toward a couple chairs. The Activity Coordinator indicated she was not aware the resident wore a wanderguard and was an elopement risk, as the resident was a new admission. The Activity Director indicated she had not engaged in any activities with the resident since her admission. The Administrator joined the conversation and indicated all staff were informed of a resident status, such as wearing a wanderguard, elopement risk or other pertinent information at their morning meetings. The Activity Coordinator indicated she must of missed the morning meeting when the resident's status was communicated. The Administrator indicated the Activity Coordinator is also the facility's driver and that was why she did not have knowledge of the new resident's status. On 7/13/22 at 12:21 P.M., a timeline was received from the Administrator. The timeline indicated the following: - 2:05 P.M. additional staff did a search by car, in surrounding area and then joined the police			

upon their arrival.

- 2:20 P.M., the family was notified.

- 2:38 P.M. the police were notified and a drone was used about 6:00 P.M.

During an interview, on 7/13/22 at 2:14 P.M., the Environmental Services Director (ESD) indicated the resident's wanderguard went off 3 times, on 7/11/22. The wanderguard was programmed to alarm staff if a resident stayed near a doorway for over 45 seconds or if a resident passed through an exit door. Resident B's alarm went off when she entered a second floor stairwell, on the southwest side of the building, when she exited the stairwell, on the first floor and when she exited the facility at the northwest doorway.

On 7/13/22 at 2:17 P.M., a video was observed with the Environmental Services Director (ESD). Resident B was observed exiting her room going towards the middle of the hallway, then observed a staff member exiting the resident's room and holding slippers in her hands. At 1:42 P.M., the resident was observed exiting the stairwell and walking down the hallway toward the north side of the building. At 1:47 P.M. the resident was observed

	near the northwest exit door at the end of the hallway. She stumbles into the door and it opens and resident walks out the door and goes to her right and then is out of view. At 1:51 P.M., a staff member approaches the door looks outside, then goes outside, but goes no further than the doorway and returns to the facility. She is then observed to look at a device in her hand and walks briskly down the hallway. At 1:58 P.M. the ESD and 2 other staff members approach the door the resident had exited from. Looking in stairwell and at the exit door but never going outside of the building. At 2:09 P.M., staff were observed knocking on resident's doors talking with residents. At 2:22 P.M., a staff member goes out the exit door, the resident went out of and goes to the right and doesn't return into the building. The ESD indicated the walkie talkies the staff carry were how the staff were alerted the wanderguard was going off. The alarm tells the locations of where the resident caused the alarm to go off. The ESD indicated there was a list and picture of resident's at the front desk who had a wanderguard. He indicated the cameras at the front entrance were not functioning therefore there was no video of the resident after she exited the facility.			

	During an interview, on 7/14/22 at at 10:10 A.M., LPN 2 indicated she had taken care of the resident the night she was found in another resident's room, the resident had nothing on below the waist and the staff could not get her to leave the room and go to her own room. She contacted the ADOW who told her to call the sister and have her come in and assist with the resident but the sister did not answer her phone. Eventually, the resident left the room, wandered the hallway and urinated on the hallway door. LPN 2 indicated most of the evening shift she observed the resident trying other resident's doors and sitting by the elevator but never entered the elevator to go to the ground level. The LPN indicated she was told in report the resident had dementia and was wearing a wanderguard, but once she was providing care for Resident B, it had been obvious to LPN 2 the resident had severe dementia and was not appropriate for the facility. LPN 2 had not added any interventions to prevent a possible elopement. During an interview, on 7/14/22 at 10:39 A.M., QMA 4 indicated she had worked, on 7/10/22, and said the resident had pulled the fire alarm, stating she was trying to fix it. She indicated the resident was wandering on the			

	1st floor and her room was on the second floor. She indicated there were no 15 or 30 minutes checks being conducted on the resident the day she worked. During an interview, on 7/14/22 at 10:58 A.M., the DOW indicated she had indeed completed the pre-admission paperwork with the resident's sister-who answered the questions for the resident. The Elopement Risk Evaluation form was also completed by the DOW, and she indicated she was aware of the high risk factors and so was the family. The DOW spoke with the family about placing the resident in a memory care-secure unit and the family did not want to do that. She offered a respite room to see if her placement would work. Family was upset and indicated they had been working with the facility since January to get her placed. The DOW talked with the Marketing Manager and they decided to place the resident at the facility with a wanderguard. When the resident had the behavior over the weekend, it was discussed during the the morning meeting but the DOW indicated she was planning to call the family that day, to explain to them the placement wasn't going to work and have them remove the resident from the facility, but other things came up.			

	On 7/13/22 at 2:53 P.M., a telephone interview was conducted with the resident's sister/POA (Power Of Attorney) and the resident's nephew, as both were listed as emergency contacts for Resident B. The resident's sister indicated she was contacted by the facility, on 7/11/22 at 2:33 P.M., per her phone. The facility informed her that her sister went out of the facility, near the fountain, was last seen crossing the driveway and they were about ready to call the police. The nephew indicated they had been contacted about an event when the resident went into another resident's room, when she pulled the fire alarm and when she was refusing her medications. The nephew indicated the facility had promotional material indicating they could take care of resident's with dementia and the facility was designed to take care of residents with a memory problem. The nephew indicated the resident had no sense of direction. The sister indicated she had lived at home, prior to going to the facility and had never walked away from her home. Both indicated this was completely out of the ordinary for the resident. They indicated yesterday someone from the corporate offices talked to them and indicated they knew how they felt and it angered the nephew and his emotions were			

	high. A police office came to speak to them and were told the facility would not be giving them anymore information without them filing out a form, to request the resident's records and it may take up to 2-3 weeks to receive. And from now on they would only be speaking to them through the facility's attorney. Since then they have had no contact with the facility. They are getting their information from the police on the investigation. The police told them if the facility would of called sooner than 30 minutes after they realized she was gone, the resident's chances of being found would of greatly increased. The sister indicated she just did not understand how this could of happened and just wanted her sister back and safe. On 7/14/22 at 11:38 A.M., a request of the full investigation of Resident B elopement was requested from the Administrator. The Administrator indicated she would have to talk to the corporate staff, as the investigation was ongoing. She indicated staff were interviewed and a root cause analysis was being worked on. During an interview, on 7/14/22 at 2:11 P.M., the resident's sister indicated she was not present during the MMSE (Mini-Mental State Examination) nor the Elopement Risk			

	Assessment. She was never told the results, nor that the resident was inappropriate for the facility and should have been placed in a more secure facility, such as a memory care unit. The resident's sister indicated the respite room was offered due to her room not being ready (had a wrinkle in the carpet) but the facility managed to get it taken care of so the resident could move in. She indicated the police had no other information on her sister's where about's. On 7/14/22 at 2:20 P.M., a form titled "Elopement Root Cause Analysis", undated, was provided by the DOW. The form indicated, on 7/11/22 at 1:50 P.M., Resident B walked out of the facility, with a wanderguard alerting staff at 1:45 P.M. Resident B was last seen on the second floor after a staff member had taken the resident to the restroom, around 12:00-12:30 P.M. The form indicated under "Potential Interventions" the facility had reviewed the residents medications, they had photographed the resident and she was on a wander list, the resident was wearing a wanderguard, staff were aware of wander/elopement risk and resident had been evaluated by the psychiatric NP. 2. On 7/14/22 at 3:12 P.M., a			

	review of the clinical record for Resident D was conducted. The resident's diagnoses included, but was not limited to: dementia and depression. An Elopement Risk Evaluation, dated 1/31/22, indicated the resident's score was 9. A score between 6-15 indicated the resident was a moderate risk for an elopement. There was no other Elopement Risk Evaluations after this date. A Progress Note, dated 6/14/22 at 2:30 A.M., indicated "...Reporting ELOPEMENT. This writer was sitting outside the East side side-door (near big parking lot) on break when res. [resident] came walking out the door. She did not have keys and was not wearing her pendant, and door needs a key to get back into the building. She stated "I'm going home!". She said her kids dropped her off and were supposed to return to pick her up, and since they hadn't come to get her she was going to walk home. I explained to her that it was the middle of the night and her kids were home asleep, and could she please stay the night here and we would take care of her. Walked her back to her apartment and explained how pendant alerts staff and if she needed anything staff would come promptly. Tucked her into bed, she said she was very tired			

	and happy to go to bed...." A Progress note, dated 6/14/22 at 10:35 P.M. documented by DOW indicated "...Met with resident daughter today regarding resident attempted elopement last evening. Explained wanderguard and how it works. Daughter removed all scissors from resident room. Resident is currently under the care of psych [psychiatric] services with [name of company] and medications recently changed as well as treated for UTI [Urinary Tract Infection]. Per night CNA resident frequently comes to the fireplace to sit during the night. Noted by daughter that resident is sleeping in more. Will discuss with psych services. Daughter has noted a progression in dementia behaviors including inappropriate outbursts at family events. This is noted at the community when she has difficulty with processing a situation. She is still able to dress herself and provide daily hygiene. Daughter does not think she is as resistive to showers as she used to be. She is more incontinent and noted large amount of wet depends in her trash as well as wet sheets today. Daughter will discuss level of care with her brother and cost of services to decide which is best for her. Added safety checks and reminders for meals, especially breakfast to			

	get her up in the morning..." A Progress Note, dated 6/17/22 at 3:10 P.M., indicated the psychiatric NP was in the facility and a new order was received for Trazadone (a sedating anti-depressant) 50 mg. at bedtime. On 6/17/22 at 8:30 P.M., indicated "...Res [resident] found walking toward the front door, when asked where she was going she stated "I'm going home. My family hasn't come to pick me up so I'm walking home!". Explained to her she had her own apt. here and redirected back to her apt. Her bed was noted to be stripped of bedding, bedding was in a pile wrapped up with wet sheets and wet clothing. CNA summoned and assisted her to put clean, dry linens on her bed. Gatorade offered to res per daughter's previous suggestion, res declined...." A Progress note, dated 7/6/22 at 1:45 P.M., indicated the following: "...Resident removed wanderguard. Wrist red from tugging and pulling at it. Staff helped her put it back on...." A Progress Note, dated 7/13/22 at 1:30 P.M., indicated "...Daughter [name of daughter] called this writer down to resident apartment stating she needed help. Upon entering the			

bathroom where the resident and daughter were, resident noted to be shaking, repeating "I can't see, I want to talk to [name of someone], where am I". Resident kept asking who this writer was, resident did not know where she was, or what her middle name was...." The Note indicated, at 2:00 P.M., the resident was transported to a local hospital.

During an interview, on 7/14/22 at 3:35 P.M., the ADOW indicated there are no activities for residents at night, therefor the psychiatric NP was called to obtain an order for something to help the resident sleep. ADOW indicated the reason the resident's trazadone was was increased from 25 mg to 50 mg at bedtime was to help her sleep better.

3. On 7/14/22 at 6:30 P.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but were not limited to: dementia and depression.

An Elopement Risk Assessment, dated 2/22/22, indicated the resident had scored 64 and had "High Risk Factors" such as wandering, disoriented to place/time and had intermittent confusion. The Form indicated a score of 16 or higher indicated "...High Risk: Consider Recommendation to

	move to a SECURE MEMORY CARE NEIGHBORHOOD...." A Progress Note, dated 5/5/22 at 5:53 P.M., documented by the DOW indicated "...Resident used her key to access another resident room where the door was unlocked. I just happened to be in the room with that resident. Resident greeted [name of resident] politely and not surprised to see her. [Name of resident] walked in like it was her own apartment. Easily redirected without embarrassment. She was redirected back to her apartment. Talked about using her pendant for help and she was unaware of where her pendant was. Looked around her apartment and did not locate. She was not worried about missing it because she doesn't know what it is. She was holding a half sandwich and pile of fries in a napkin in her hand. It appeared to be her whole dinner. She offered it to me and said she was not hungry. Food was left in her apartment. Called daughter [name of daughter] and left message to call back tomorrow...." A Progress Note, dated 5/6/22 at 2:02 P.M., indicated "...Daughter , [name of daughter], returned call. Informed of recent events with her mom. Discussed level of care. She wants to keep her			

	mom here as long as possible. Her mom told her that she feels safe here. She is surprised at the decline in the 8 months that she has lived at Cedarhurst. Reviewed tasks we can help her mom with to improve her safety. Added showers 2 times per week. \We do not feel she will allow this but will get staff interaction to get her to trust the staff. Added increase in redirection when resident gets turned around in the community and cannot find her apartment. She does not call for assistance. Daughter states she keeps the pendant in her room next to her favorite chair. Also added dressing assistance to help her pick out her clothes. She has piles of clothes all over her room and her daughter says this is normal for her. She agreed to the increase in cost for the increase in her level of care..." A Progress Note, dated 7/10/22 at 6:30 P.M., documented by QMA 4 indicated "...Resident got out the building twice on eastside side door. Resident wanderguard did not inform staff nor ipods...." A Progress Note, dated 7/11/22 at 6:50 A.M., indicated QMA 6 replaced and tested resident's wanderguard. During an interview, on 7/14/22 at 2:41 P.M., QMA 4 indicated, on 7/10/22, Resident E was			

	found outside a facility door, on the east side of the building, sitting in a chair. QMA 4 indicated the resident's alarm had not alerted the staff Resident E was out of the building. Another resident had informed QMA 4, the resident was outside by herself. About 20 minutes later QMA 4 observed the resident go out the same door, so the QMA returned the resident, inside the building, and relocated the resident to the front common area. She reported the incident the DON via a phone call. QMA was told by the DON to check the wanderguard and it was functioning properly. She also checked each resident in the facility, wearing a wanderguard, to ensure they were working. She was not given any further direction by the DON. During an interview, on 7/14/22 at 4:07 P.M., the Administrator indicated she was not notified of Resident E's elopement, as she was on vacation and the DOW had handled the situation, the reporting and investigation. She was not aware of any other precautions and/or interventions concerning Resident D or Resident E who wore wanderguards, who resided at the facility, post their elopement attempts or after Resident B came up missing. No self-reported incidents were			

	received regarding Resident E's elopement from the facility. On 7/13/22 at 12:21 P.M., the Administrator provided a policy titled, "Abuse, Neglect and Exploitation Prevention Prohibition, and Investigation", dated 3/14/22 and indicated the policy was the one currently used by the facility. The policy indicated "... "Abuse" means: *Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a Resident...*Results in physical harm or discomfort, or loss of human dignity, failure to provide agreed upon care or services to a Resident, failure to make a reasonable effort to assess what care is necessary for the well-being of the Resident, or failure to provide a safe and sanitary environment. On 7/14/22 at 4:02 P.M., the Administrator provided a policy titled, "Elopement Risk", dated 3/24/22, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: It is the [name of facility] policy that all Residents are evaluated for elopement risk to identify level of risk which may lead to elopement. An elopement risk assessment will be completed: *Upon move in			

	*Every 6 months *Change of status/condition as it relates to unsafe wandering *Post elopement or attempted elopement *As required by state regulations...." An exit conference was conducted on 7/14/22 from 5:05 P.M.- 5:09 P.M., with the Administrator and the DOW. At the exit conference, the Administrator indicated the whereabouts of Resident B had not yet been established. This State tag relates to complaint IN00385169. Based on observation, record review and interview, the facility failed to ensure residents were free from neglect, related to no additional interventions, besides a wanderguard, to prevent 3 of 3 residents, with exit seeking behaviors and cognitively impaired, from exiting the facility unattended, resulting in one resident not being located for over 72 hours. (Resident B, Resident D and Resident E) Findings include: 1. On 7/13/22 at 10:11 A.M., a review of the clinical record for Resident B was conducted. The resident was admitted on 7/5/22. The resident's			

diagnoses included, but were not limited to: dementia, major depressive disorder, osteoarthritis of knee and diabetic. The resident was 83 years old.

A Prospective Resident Health Assessment form, dated 6/28/22, indicated the resident had wandering behaviors and searched in her apartment for things, she had currently been falling 2 times a week and had hallucinations-seeing people in her room.

An Elopement Risk Evaluation, dated 6/28/22, indicated the resident's score was 12. A score between 6-15 indicated the resident was a moderate risk for an elopement. The form indicated the resident had "high risk" factors which included the following: the resident was disoriented to time and place and had intermittent confusion. The form stated "...NOTE: If any of the HIGH RISK FACTORS are present, secured neighborhood is recommended ...."

A MMSE (Mini-Mental State Examination), undated, indicated the resident's score was 8 out of 30, with a score less than 9 stating severe cognitive impairment.

A form titled, "Individualized Service Plan", dated 6/28/22,

	indicated the resident needed a wanderguard (an alert system to inform staff if a resident was in an off limit area). The wanderguard would be placed on the resident for her safety, but the plan indicated the resident would "need guidance on where to go and sit". A Progress Note, dated 7/5/22 at 11:00 A.M., indicated Resident B was admitted to apartment 219, from home brought to community by her sister. A Progress Note, dated 7/6/22 at 7:45 P.M. indicated "...Res. [resident] in apartment, refusing to allow CNA to help her into pajamas, wants to wear them over her clothing. Res. [resident] attempting to verbalize but staff unable to make any sense of what she is trying to say at times, told CNA she needed to wear clothing under her pajamas because she is 'undercover'. Res [resident] holding a [name of facility] calendar, saying she was looking for phone numbers of people to call, using her TV remote as a phone. Refuses to let CNA check her to see if she is wet...." A Progress Note, dated 7/7/22 at 10:00 P.M., documented by LPN 2 indicated "...Res [resident] wandering throughout the West 2nd floor hall for the			

	past several hours, set off a "loiter alert" near the 2nd floor northwest stairwell several times since 7pm. Observed by other residents trying to open mechanical room and storage room doors. Noted to be carrying a large vase of flowers around. Entered the apartment of another res while this writer was passing hs[bedtime] meds [medications]. Returned her to her room. Res [resident] returned to the area near the upstairs west elevator, seated in a chair. Hs [bedtime] meds [medications] taken without difficulty...." A Progress Note, dated 7/8/22 at 3:15 A.M., documented by LPN 2 indicated the following; "...Summoned to apt. [apartment] #222 by resident of apt. [apartment] #222 at approx. [approximately] 12:30 am, when CNA responded he found [name of Resident B], who lives in apt. #219, in his apt. She had urinated in his recliner, and then removed her wet brief and tossed it on the floor, and then went and sat down on his couch, naked from the waist down. She refused to leave apt. #222, saying that it was her apt. [apartment]and staff should leave her alone. CNA called this nurse to the apt. [apartment] where I found [name of Resident B] sitting on the couch, naked from the waist down. Assistant Wellness Director			

	[name of LPN 5] was contacted and she advised that I call her sister/POA [name of sister] to come to the facility and remove her sister from apt. #222. There was no answer and a voicemail was left. [Name of LPN 5] then gave the okay to attempt to contact her nephew [name of nephew]. No answer. Staff was directed to come up with creative ways to get her to exit the apt. [apartment], to no avail. She refused offers of something to drink or a treat. She just kept repeatedly asking, sometimes yelling, at staff to leave her alone so she could go to sleep. Staff stayed with her in apt. [apartment] #222 in order to keep both her and the occupant res [resident] safe. Two staff stayed in the apt. [apartment] and attempted to reason with her. [Name of Resident B] became combative, trying to hit CNA and myself several times. She couldn't understand why staff would not leave and let her go to sleep on the couch. At approx. [approximately] 2:45 am [name of Resident B] said she had to urinate, and that she was going to urinate "over there" pointing to the corner of apt. [apartment] 222's living room. When her path was blocked by staff, she walked toward the apt's. [apartments] open door, stopped for a few minutes in the doorway, and then exited the apt. [apartment] She walked north down the hallway, trying to			

	open each apt. [apartment] door as she went, and urinating in several places on the carpet throughout the hall. When she reached the end of the hall she turned around, and made her way back to her own apt. [apartment] #219. The door to her apt. [apartment] was open, and she went in, locking her door behind her...." A Progress Note, dated 7/8/22 at 10:39 A.M., indicated the physician was contacted, by the Assistant Wellness Director/LPN 5 to report the resident's blood pressure and the resident was complaining of right hip pain. The Note indicated the resident was having difficulty walking. A form titled, "Psychiatry Initial Consult", dated 7/8/22, indicated the resident was seen in her room using a video interface platform. The resident was pleasant during the assessment and indicated she was adjusting to her new surroundings. The staff reported, the resident was up wandering at night, having exit seeking behaviors, going into others' apartments and urinating in inappropriate places, which was likely a combination of new surroundings and BPSD (Behavioral and Psychological Symptoms of Dementia.) The form indicated nursing was to monitor and document any new or worsening moods and/or			

behaviors.

A Progress Note, dated 7/8/22 at 1:27 P.M., documented by the Assistant Director of Wellness (ADOW) indicated the resident had a telehealth visit with the psychiatric Nurse Practitioner (NP). The NP wrote new orders for Resident to start Zoloft (anti-depressant) 50 milligrams (mg), 1 tablet daily, Trazadone (sedating anti-depressant) 50 mg, 1 tablet at bedtime, and Rivastigmine (treatment for Alzheimer's Disease) 1.5 mg 1 tablet, at bedtime. The resident's sister was notified of the additional medications.

A Progress Note, dated 7/10/22 at 6:56 A.M., documented by Qualified Medication Assistant (QMA) 6 indicated "...Up all night. Opening residents doors. Refused evening meds [medications]. Aggressive towards staff, stated she was calling police. Redirected put on 15 min [minute] checks, then 30 mins. [minutes]. Set off elopement alarm. Did not sleep till 5am...."

A Progress Noted, dated 7/10/22 at 6:34 P.M., documented by QMA 4 indicated "...Resident pulled fire alarm, resident also is taking things off of other residents doors...."

	A Progress Note, dated 7/11/22 at 6:00 P.M., documented by the Director of Wellness (DOW) indicated "...Resident walked out of the building and wanderguard was set off at approx 2:05pm. Staff immediately responded and did not see resident when they looked out the exit. Resident was seen by postal worker about that time walking east on [a local street]. She had on maroon short sleeved shirt and tan pants and pink slippers. DON notified. ED [Executive Director] notified. Sister [name of sister] notified. [Name of city] police notified. Search ensued with all staff assisting in the search or at communication points through out the neighborhood. Search by staff in cars and on foot. Police and staff also searched at resident previous address. Resident has not been found. Family here and actively involved in search including sister [name of sister] and nephew [name of nephew]. Called and left message for [name of physician]. Silver Alert posted by police. Drone search completed. Reporting ELOPEMENT...." An Incident Report #107, dated 7/11/22, indicated at 1:45 P.M., a wanderguard alarm alerted staff to a stairwell on the westside of the building. Within 4 minutes nursing staff went to the stairwell and did not see			

	anyone around the stairwell or outside. They continued to check all the residents, with a wanderguard and noted resident in room 219 was missing. The Report indicated all the apartments and rooms in the building were searched. Nursing noted resident was seen outside in the front circle area. The adjacent properties were immediately searched and the resident was not located. The Executive Director was out of state and was notified of the situation. The resident's sister /POA was notified and she immediately came to the facility to help in the search effort. The local police were notified immediately and responded in the search. After 2 hours the police initiated a "Silver Alert", media alert and started using a drone to search the area. The resident's physician was notified of the situation. The preventative measures in place were a wanderguard and psychiatric services, which had been initiated on 7/8/22. A request for the complete investigation was requested and a timeline was received. During an interview, on 7/13/22 at 12:02 P.M., the Activity Coordinator described the events, on 7/11/22 just prior to 2:00 P.M. The Activity Coordinator indicated she observed Resident B outside, on the far center, of the circle			

	driveway, and the resident was wearing pink slippers. She said the resident was walking slowly toward a couple chairs. The Activity Coordinator indicated she was not aware the resident wore a wanderguard and was an elopement risk, as the resident was a new admission. The Activity Director indicated she had not engaged in any activities with the resident since her admission. The Administrator joined the conversation and indicated all staff were informed of a resident status, such as wearing a wanderguard, elopement risk or other pertinent information at their morning meetings. The Activity Coordinator indicated she must of missed the morning meeting when the resident's status was communicated. The Administrator indicated the Activity Coordinator is also the facility's driver and that was why she did not have knowledge of the new resident's status. On 7/13/22 at 12:21 P.M., a timeline was received from the Administrator. The timeline indicated the following: - 2:05 P.M. additional staff did a search by car, in surrounding area and then joined the police upon their arrival. - 2:20 P.M., the family was notified.			

	- 2:38 P.M. the police were notified and a drone was used about 6:00 P.M. During an interview, on 7/13/22 at 2:14 P.M., the Environmental Services Director (ESD) indicated the resident's wanderguard went off 3 times, on 7/11/22. The wanderguard was programmed to alarm staff if a resident stayed near a doorway for over 45 seconds or if a resident passed through an exit door. Resident B's alarm went off when she entered a second floor stairwell, on the southwest side of the building, when she exited the stairwell, on the first floor and when she exited the facility at the northwest doorway. On 7/13/22 at 2:17 P.M., a video was observed with the Environmental Services Director (ESD). Resident B was observed exiting her room going towards the middle of the hallway, then observed a staff member exiting the resident's room and holding slippers in her hands. At 1:42 P.M., the resident was observed exiting the stairwell and walking down the hallway toward the north side of the building. At 1:47 P.M. the resident was observed near the northwest exit door at the end of the hallway. She stumbles into the door and it opens and resident walks out the door and goes to her right			

	and then is out of view. At 1:51 P.M., a staff member approaches the door looks outside, then goes outside, but goes no further than the doorway and returns to the facility. She is then observed to look at a device in her hand and walks briskly down the hallway. At 1:58 P.M. the ESD and 2 other staff members approach the door the resident had exited from. Looking in stairwell and at the exit door but never going outside of the building. At 2:09 P.M., staff were observed knocking on resident's doors talking with residents. At 2:22 P.M., a staff member goes out the exit door, the resident went out of and goes to the right and doesn't return into the building. The ESD indicated the walkie talkies the staff carry were how the staff were alerted the wanderguard was going off. The alarm tells the locations of where the resident caused the alarm to go off. The ESD indicated there was a list and picture of resident's at the front desk who had a wanderguard. He indicated the cameras at the front entrance were not functioning therefore there was no video of the resident after she exited the facility. During an interview, on 7/14/22 at at 10:10 A.M., LPN 2 indicated she had taken care of the resident the night she was found in another resident's			

	room, the resident had nothing on below the waist and the staff could not get her to leave the room and go to her own room. She contacted the ADOW who told her to call the sister and have her come in and assist with the resident but the sister did not answer her phone. Eventually, the resident left the room, wandered the hallway and urinated on the hallway door. LPN 2 indicated most of the evening shift she observed the resident trying other resident's doors and sitting by the elevator but never entered the elevator to go to the ground level. The LPN indicated she was told in report the resident had dementia and was wearing a wanderguard, but once she was providing care for Resident B, it had been obvious to LPN 2 the resident had severe dementia and was not appropriate for the facility. LPN 2 had not added any interventions to prevent a possible elopement.			

	During an interview, on 7/14/22 at 10:39 A.M., QMA 4 indicated she had worked, on 7/10/22, and said the resident had pulled the fire alarm, stating she was trying to fix it. She indicated the resident was wandering on the 1st floor and her room was on the second floor. She indicated there were no 15 or 30 minutes checks being conducted on the resident the day she worked. During an interview, on 7/14/22 at 10:58 A.M., the DOW indicated she had indeed completed the pre-admission paperwork with the resident's sister-who answered the questions for the resident. The Elopement Risk Evaluation form was also completed by the DOW, and she indicated she was aware of the high risk factors and so was the family. The DOW spoke with the family about placing the resident in a memory care-secure unit and the family did not want to do that. She offered a respite room to see if her placement would work. Family was upset and indicated they had been working with the facility since January to get her placed. The DOW talked with the Marketing Manager and they decided to place the resident at the facility with a wanderguard. When the resident had the behavior over the weekend, it was discussed during the the morning meeting but the DOW indicated she was			

planning to call the family that day, to explain to them the placement wasn't going to work and have them remove the resident from the facility, but other things came up.

On 7/13/22 at 2:53 P.M., a telephone interview was conducted with the resident's sister/POA (Power Of Attorney) and the resident's nephew, as both were listed as emergency contacts for Resident B. The resident's sister indicated she was contacted by the facility, on 7/11/22 at 2:33 P.M., per her phone. The facility informed her that her sister went out of the facility, near the fountain, was last seen crossing the driveway and they were about ready to call the police. The nephew indicated they had been contacted about an event when the resident went into another resident's room, when she pulled the fire alarm and when she was refusing her medications. The nephew indicated the facility had promotional material indicating they could take care of resident's with dementia and the facility was designed to take care of residents with a memory problem. The nephew indicated the resident had no sense of direction. The sister indicated she had lived at home, prior to going to the facility and had never walked away from her home. Both indicated this was

	completely out of the ordinary for the resident. They indicated yesterday someone from the corporate offices talked to them and indicated they knew how they felt and it angered the nephew and his emotions were high. A police office came to speak to them and were told the facility would not be giving them anymore information without them filing out a form, to request the resident's records and it may take up to 2-3 weeks to receive. And from now on they would only be speaking to them through the facility's attorney. Since then they have had no contact with the facility. They are getting their information from the police on the investigation. The police told them if the facility would of called sooner than 30 minutes after they realized she was gone, the resident's chances of being found would of greatly increased. The sister indicated she just did not understand how this could of happened and just wanted her sister back and safe.			

	On 7/14/22 at 11:38 A.M., a request of the full investigation of Resident B elopement was requested from the Administrator. The Administrator indicated she would have to talk to the corporate staff, as the investigation was ongoing. She indicated staff were interviewed and a root cause analysis was being worked on. During an interview, on 7/14/22 at 2:11 P.M., the resident's sister indicated she was not present during the MMSE (Mini-Mental State Examination) nor the Elopement Risk Assessment. She was never told the results, nor that the resident was inappropriate for the facility and should have been placed in a more secure facility, such as a memory care unit. The resident's sister indicated the respite room was offered due to her room not being ready (had a wrinkle in the carpet) but the facility managed to get it taken care of so the resident could move in. She indicated the police had no other information on her sister's where about's. On 7/14/22 at 2:20 P.M., a form titled "Elopement Root Cause Analysis", undated, was provided by the DOW. The form indicated, on 7/11/22 at 1:50 P.M., Resident B walked out of the facility, with a wanderguard alerting staff at 1:45 P.M.			

	Resident B was last seen on the second floor after a staff member had taken the resident to the restroom, around 12:00-12:30 P.M. The form indicated under "Potential Interventions" the facility had reviewed the residents medications, they had photographed the resident and she was on a wander list, the resident was wearing a wanderguard, staff were aware of wander/elopement risk and resident had been evaluated by the psychiatric NP. 2. On 7/14/22 at 3:12 P.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but was not limited to: dementia and depression. An Elopement Risk Evaluation, dated 1/31/22, indicated the resident's score was 9. A score between 6-15 indicated the resident was a moderate risk for an elopement. There was no other Elopement Risk Evaluations after this date. A Progress Note, dated 6/14/22 at 2:30 A.M., indicated "...Reporting ELOPEMENT. This writer was sitting outside the East side side-door (near big parking lot) on break when res. [resident] came walking out the door. She did not have keys and was not wearing her pendant, and door needs a key			

	to get back into the building. She stated "I'm going home!". She said her kids dropped her off and were supposed to return to pick her up, and since they hadn't come to get her she was going to walk home. I explained to her that it was the middle of the night and her kids were home asleep, and could she please stay the night here and we would take care of her. Walked her back to her apartment and explained how pendant alerts staff and if she needed anything staff would come promptly. Tucked her into bed, she said she was very tired and happy to go to bed...." A Progress note, dated 6/14/22 at 10:35 P.M. documented by DOW indicated "...Met with resident daughter today regarding resident attempted elopement last evening. Explained wanderguard and how it works. Daughter removed all scissors from resident room. Resident is currently under the care of psych [psychiatric] services with [name of company] and medications recently changed as well as treated for UTI [Urinary Tract Infection]. Per night CNA resident frequently comes to the fireplace to sit during the night. Noted by daughter that resident is sleeping in more. Will discuss with psych services. Daughter has noted a progression in dementia behaviors including			

	inappropriate outbursts at family events. This is noted at the community when she has difficulty with processing a situation. She is still able to dress herself and provide daily hygiene. Daughter does not think she is as resistive to showers as she used to be. She is more incontinent and noted large amount of wet depends in her trash as well as wet sheets today. Daughter will discuss level of care with her brother and cost of services to decide which is best for her. Added safety checks and reminders for meals, especially breakfast to get her up in the morning..." A Progress Note, dated 6/17/22 at 3:10 P.M., indicated the psychiatric NP was in the facility and a new order was received for Trazadone (a sedating anti-depressant) 50 mg. at bedtime. On 6/17/22 at 8:30 P.M., indicated "...Res [resident] found walking toward the front door, when asked where she was going she stated "I'm going home. My family hasn't come to pick me up so I'm walking home!". Explained to her she had her own apt. here and redirected back to her apt. Her bed was noted to be stripped of bedding, bedding was in a pile wrapped up with wet sheets and wet clothing. CNA summoned and assisted her to put clean,			

	dry linens on her bed. Gatorade offered to res per daughter's previous suggestion, res declined...." A Progress note, dated 7/6/22 at 1:45 P.M., indicated the following: "...Resident removed wanderguard. Wrist red from tugging and pulling at it. Staff helped her put it back on...." A Progress Note, dated 7/13/22 at 1:30 P.M., indicated "...Daughter [name of daughter] called this writer down to resident apartment stating she needed help. Upon entering the bathroom where the resident and daughter were, resident noted to be shaking, repeating "I can't see, I want to talk to [name of someone], where am I". Resident kept asking who this writer was, resident did not know where she was, or what her middle name was...." The Note indicated, at 2:00 P.M., the resident was transported to a local hospital.			

	During an interview, on 7/14/22 at 3:35 P.M., the ADOW indicated there are no activities for residents at night, therefor the psychiatric NP was called to obtain an order for something to help the resident sleep. ADOW indicated the reason the resident's trazadone was was increased from 25 mg to 50 mg at bedtime was to help her sleep better. 3. On 7/14/22 at 6:30 P.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but were not limited to: dementia and depression. An Elopement Risk Assessment, dated 2/22/22, indicated the resident had scored 64 and had "High Risk Factors" such as wandering, disoriented to place/time and had intermittent confusion. The Form indicated a score of 16 or higher indicated "...High Risk: Consider Recommendation to move to a SECURE MEMORY CARE NEIGHBORHOOD...." A Progress Note, dated 5/5/22 at 5:53 P.M., documented by the DOW indicated "...Resident used her key to access another resident room where the door was unlocked. I just happened to be in the room with that resident. Resident greeted [name of resident] politely and not surprised to see her. [Name			

	of resident] walked in like it was her own apartment. Easily redirected without embarrassment. She was redirected back to her apartment. Talked about using her pendant for help and she was unaware of where her pendant was. Looked around her apartment and did not locate. She was not worried about missing it because she doesn't know what it is. She was holding a half sandwich and pile of fries in a napkin in her hand. It appeared to be her whole dinner. She offered it to me and said she was not hungry. Food was left in her apartment. Called daughter [name of daughter] and left message to call back tomorrow...." A Progress Note, dated 5/6/22 at 2:02 P.M., indicated "...Daughter , [name of daughter], returned call. Informed of recent events with her mom. Discussed level of care. She wants to keep her mom here as long as possible. Her mom told her that she feels safe here. She is surprised at the decline in the 8 months that she has lived at Cedarhurst. Reviewed tasks we can help her mom with to improve her safety. Added showers 2 times per week. \We do not feel she will allow this but will get staff interaction to get her to trust the staff. Added increase in redirection when resident gets			

	turned around in the community and cannot find her apartment. She does not call for assistance. Daughter states she keeps the pendant in her room next to her favorite chair. Also added dressing assistance to help her pick out her clothes. She has piles of clothes all over her room and her daughter says this is normal for her. She agreed to the increase in cost for the increase in her level of care..." A Progress Note, dated 7/10/22 at 6:30 P.M., documented by QMA 4 indicated "...Resident got out the building twice on eastside side door. Resident wanderguard did not inform staff nor ipods...." A Progress Note, dated 7/11/22 at 6:50 A.M., indicated QMA 6 replaced and tested resident's wanderguard. During an interview, on 7/14/22 at 2:41 P.M., QMA 4 indicated, on 7/10/22, Resident E was found outside a facility door, on the east side of the building, sitting in a chair. QMA 4 indicated the resident's alarm had not alerted the staff Resident E was out of the building. Another resident had informed QMA 4, the resident was outside by herself. About 20 minutes later QMA 4 observed the resident go out the same door, so the QMA returned the resident, inside the			

	building, and relocated the resident to the front common area. She reported the incident the DON via a phone call. QMA was told by the DON to check the wanderguard and it was functioning properly. She also checked each resident in the facility, wearing a wanderguard, to ensure they were working. She was not given any further direction by the DON. During an interview, on 7/14/22 at 4:07 P.M., the Administrator indicated she was not notified of Resident E's elopement, as she was on vacation and the DOW had handled the situation, the reporting and investigation. She was not aware of any other precautions and/or interventions concerning Resident D or Resident E who wore wanderguards, who resided at the facility, post their elopement attempts or after Resident B came up missing. No self-reported incidents were received regarding Resident E's elopement from the facility. On 7/13/22 at 12:21 P.M., the Administrator provided a policy titled, "Abuse, Neglect and Exploitation Prevention Prohibition, and Investigation", dated 3/14/22 and indicated the policy was the one currently used by the facility. The policy indicated "... "Abuse" means: *Any act or failure to act			

	performed intentionally or recklessly that causes or is likely to cause harm to a Resident...*Results in physical harm or discomfort, or loss of human dignity, failure to provide agreed upon care or services to a Resident, failure to make a reasonable effort to assess what care is necessary for the well-being of the Resident, or failure to provide a safe and sanitary environment. On 7/14/22 at 4:02 P.M., the Administrator provided a policy titled, "Elopement Risk", dated 3/24/22, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: It is the [name of facility] policy that all Residents are evaluated for elopement risk to identify level of risk which may lead to elopement. An elopement risk assessment will be completed: *Upon move in *Every 6 months *Change of status/condition as it relates to unsafe wandering *Post elopement or attempted elopement *As required by state regulations...." An exit conference was conducted on 7/14/22 from 5:05 P.M.- 5:09 P.M., with the			

	Administrator and the DOW. At the exit conference, the Administrator indicated the whereabouts of Resident B had not yet been established. This State tag relates to complaint IN00385169.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.	R 0090	R 90 Administration and Management -Deficiency 1. 1. The corrective action that was put in place for the facility's Administrator failing to ensure incidents of elopement were investigated and reported to the Department of Health for 1 of 3 residents reviewed for elopements, is that an all staff in-service was given by the Director of Wellness and the Administrator on July 27, 2022, instructing all staff to immediately notify both the Director of Wellness or designee and the Administrator or designee upon a resident who has a wanderguard or a resident who has been identified to have a score lower than 15 on the mini mental, who has exited the building unattended. The Regional Director of Operations or designee or the Regional Director of Wellness or	09/13/2022

	(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility's Administrator failed to ensure incidents of elopement were investigated and reported to the		designee will oversee the Administrator and the Director of Wellness to ensure polices are followed. The Director of Wellness or designee will continue to meet with staff during the daily stand-up meetings and discuss any concerns and current policies. The Administrator or designee or the Director or Wellness or designee will notify the Indiana State Board of Health within 24 hours of the dementia resident exiting the building/premises. 2. 2. To ensure immediate compliance with the state regulations, all current residents who have mini mental scores lower than 15 or any resident with wandering tendencies will be identified at daily stand- up meetings as well as posted in the nurse’s station and front desk and all managers will be notified of any resident scoring lower than a 15 on the mini mental as well. If a resident demonstrates wandering tendencies the Director of Wellness or designee will put in place frequent checks to ensure the safety of this resident.	

	Department of Health for 1 of 3 residents reviewed for elopements. (Resident E) Finding includes: On 7/14/22 at 6:30 P.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but were not limited to: dementia and depression. An Elopement Risk Assessment, dated 2/22/22, indicated the resident had scored 64 and had "High Risk Factors" such as wandering, disoriented to place/time and had intermittent confusion. The Form indicated a score of 16 or higher indicated "...High Risk: Consider Recommendation to move to a SECURE MEMORY CARE NEIGHBORHOOD...." A Progress Note, dated 7/10/22 at 6:30 P.M., documented by QMA 4 indicated "...Resident got out the building twice on eastside side door. Resident wanderguard did not inform staff nor ipods...." A Progress Note, dated 7/11/22 at 6:50 A.M., indicated QMA 6 replaced and tested resident's wanderguard. During an interview, on 7/14/22 at 2:41 P.M., QMA 4 indicated, on 7/10/22, Resident E was found outside the door on the east side of the building, sitting		3. 3.Administrator or designee and Director of Wellness or designee will set up meetings with family members who's loved one has been identified as scoring lower than 15 on the mini mental. Discussions will be held regarding the mini mental score and possibility of needing a secure memory care unit or private duty caregiver to ensure the resident's safety. Family may hire a private duty caregiver or the family themselves may arrange to stay with the resident to ensure the resident's safety. Family may also decide to discharge their loved one to a secure memory care unit.	

	in a chair. QMA 4 indicated the resident's alarm had not alerted the staff, Resident E was out of the building. Another resident had informed QMA 4, the resident was outside by herself. About 20 minutes later QMA 4 observed the resident go out the same door, so the QMA returned the resident, inside the building, and relocated the resident to the front common area. She reported the incident the DOW via a phone call. QMA was told by the DOW to check the wanderguard and it was functioning properly. She also checked each resident in the facility, wearing a wanderguard to make sure they were working. She was not given any further direction by the DOW. During an interview, on 7/14/22 at 4:07 P.M. the Administrator indicated she was not notified of the elopement of Resident E as she was on vacation and the DOW handled the situation, the reporting and investigation. She was not aware of any other precautions and/or interventions concerning Resident E who wore a wanderguard and resided at the facility, post her elopement attempt nor after Resident B came up missing. No self-reported incidents were received regarding Resident E's elopement from the facility. On 7/14/22 at 10:14 A.M., the		4. 4. The Director of Wellness or designee will communicate to the Administrator or designee upon annual assessments or significant change assessments if the mini mental score is lower than 15 and within 7 days Director of Wellness or designee or the Administrator or designee will contact the resident's responsible party and set up a care plan conference with the family to discuss immediate options for obtaining the safety of the resident with dementia. 5. 5.All mini mental examination scores of current residents will be reviewed by Assistant Director of Wellness or designee and Director of Wellness or designee and reported to the Administrator or designee by August 30, 2022. At that time, if any scores are below 15 then the Administrator or designee will contact the POA or emergency contact for that resident and request a meeting to discuss the safety of the resident and what parameters will be put in place to ensure the safety of the resident. These meetings will be held by September 13, 2022 and that is also the date to have	

	Administrator provided a policy titled, "Accidents & Incidents", dated 3/14/22, and indicated the policy was the one currently used by the facility. The policy indicated "...The lead employee during the shift is responsible for obtaining all preliminary information (including demographic information, incident details, notifications, and witness statements) on the incident report. NOTE: Any alleged abuse or elopement must be immediately reported to the Director of Wellness and Executive Director. The DOW [Director of Wellness] and ED [Executive Director] are responsible for completing the investigation portion of the incident report process, including record review, witness statement collection and review, and investigation synopsis. When incident are state reportable, all incident investigation documentation will be kept in a binder in the ED's [Executive Director] office...." On 7/14/22 at 4:02 P.M., the Administrator provided a policy titled, "Elopement Risk", dated 3/24/22, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: It is the [name of facility] policy that all Residents are evaluated for elopement risk to identify level of risk which may lead to elopement. An elopement risk assessment will		all plan of corrections completed for deficiency R52 and R90.	

be completed:

*Upon move in

*Every 6 months

*Change of status/condition as it relates to unsafe wandering

*Post elopement or attempted elopement

*As required by state regulations...."

This State tag relates to complaint IN00385169.

Based on interview and record review, the facility's Administrator failed to ensure incidents of elopement were investigated and reported to the Department of Health for 1 of 3 residents reviewed for elopements. (Resident E)

Finding includes:

On 7/14/22 at 6:30 P.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but were not limited to: dementia and depression.

An Elopement Risk Assessment, dated 2/22/22, indicated the resident had scored 64 and had "High Risk Factors" such as wandering, disoriented to place/time and had intermittent confusion. The Form indicated a score of 16 or

higher indicated "...High Risk: Consider Recommendation to move to a SECURE MEMORY CARE NEIGHBORHOOD...."

A Progress Note, dated 7/10/22 at 6:30 P.M., documented by QMA 4 indicated "...Resident got out the building twice on eastside side door. Resident wanderguard did not inform staff nor ipods...."

A Progress Note, dated 7/11/22 at 6:50 A.M., indicated QMA 6 replaced and tested resident's wanderguard.

During an interview, on 7/14/22 at 2:41 P.M., QMA 4 indicated, on 7/10/22, Resident E was found outside the door on the east side of the building, sitting in a chair. QMA 4 indicated the resident's alarm had not alerted the staff, Resident E was out of the building. Another resident had informed QMA 4, the resident was outside by herself. About 20 minutes later QMA 4 observed the resident go out the same door, so the QMA returned the resident, inside the building, and relocated the resident to the front common area. She reported the incident the DOW via a phone call. QMA was told by the DOW to check the wanderguard and it was functioning properly. She also checked each resident in the facility, wearing a wanderguard to make sure they were working.

She was not given any further direction by the DOW.

During an interview, on 7/14/22 at 4:07 P.M. the Administrator indicated she was not notified of the elopement of Resident E as she was on vacation and the DOW handled the situation, the reporting and investigation. She was not aware of any other precautions and/or interventions concerning Resident E who wore a wanderguard and resided at the facility, post her elopement attempt nor after Resident B came up missing.

No self-reported incidents were received regarding Resident E's elopement from the facility.

On 7/14/22 at 10:14 A.M., the Administrator provided a policy titled, "Accidents & Incidents", dated 3/14/22, and indicated the policy was the one currently used by the facility. The policy indicated "...The lead employee during the shift is responsible for obtaining all preliminary information (including demographic information, incident details, notifications, and witness statements) on the incident report. NOTE: Any alleged abuse or elopement must be immediately reported to the Director of Wellness and Executive Director. The DOW [Director of Wellness] and ED [Executive Director] are responsible for completing the

investigation portion of the incident report process, including record review, witness statement collection and review, and investigation synopsis. When incident are state reportable, all incident investigation documentation will be kept in a binder in the ED's [Executive Director] office...."

On 7/14/22 at 4:02 P.M., the Administrator provided a policy titled, "Elopement Risk", dated 3/24/22, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: It is the [name of facility] policy that all Residents are evaluated for elopement risk to identify level of risk which may lead to elopement. An elopement risk assessment will be completed:

*Upon move in

*Every 6 months

*Change of status/condition as it relates to unsafe wandering

*Post elopement or attempted elopement

*As required by state regulations...."

This State tag relates to complaint IN00385169.

instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE