STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG MEADOWS ASSISTED LIVING	7133 MEADOW TRAIL, BROWNSBURG, , 46112

(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 IN00376166, IN00376169, IN00379118, and IN00380501. Complaint IN00376166 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00376169 - Unsubstantiated due to lack of evidence. Complaint IN00379118 - Substantiated. State Residential finding related to the allegations is cited at R0217. Complaint IN00380501 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: June 10 and 13, 2022 Facility number: 013356 Residential Census: 77	R 0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider or an conclusion set forth in the state of deficiencies, or of any violation or regulation. This provider respectfully request that this Plan of Correction be considered the letter of Credible Allegation and Requests a Desk Review in lieu of a Post Survey Review.	

	This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on June 21, 2022.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.	R 0217	**1.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** With regards to Resident E being found outside of the MC neighborhood the resident was escorted back to his apartment. No negative outcome was determined for Resident E. Residents service plan has been updated. Resident place on psychosocial well being precautions. Family and staff agree to encourage resident to participate on outdoor walk and activities with supervision. MC staff has received coaching and counseling moments regarding resident safety and ensuring all exit doors are secured. **2.**	07/13/2022

	(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure a resident assessed to require a secure neighborhood did not independently exit the neighborhood through 2 unsecured and unsupervised exit doors for 1 of 2 residents reviewed for elopement risk in a sample of 6 residents reviewed for implementation of service plan. (Resident E) Findings include: Resident E's clinical records were reviewed on June 10, 2022 at 11:50 a.m. Diagnoses included, but were not limited to, Parkinson's disease and other involuntary movements, dementia with Lewy bodies, vascular dementia with behavioral disturbances, unspecified disorientation, and unsteadiness on feet with other abnormalities of gait and mobility.		**How will the facility identify other residents having the potential to be affected by the same deficient practice and how what corrective action will be taken?** All MC residents have the potential to be affected. No resident was adversely affected. All staff were re-educated by July 8, 2022 on Elopement policy and procedure, including but not limited to keeping memory care doors secured at all times. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Director of Nursing Services and Memory Care Specialist will review the Pre-Admission Checklist, and structure activities accordingly to the resident's individual service plans. All staff were re-educated by July 8, 2022 on	

An undated, Pre-Admission Criteria Checklist indicated Resident E required a secure memory care neighborhood due to having a diagnosis of dementia, would benefit from structured activities to assist with daily orientation, and would benefit having increased assistance with activities of daily living in a structured environment.

A current Memory Care Service Plan, with a completed date of November 15, 2021, indicated a secure memory care neighborhood was provided. Resident E was daily provided with hands on assistance with activities of daily living, monitoring for use of an assistive device during ambulation, and observation due to wandering behaviors that required redirection. Resident E's cognitive abilities for daily decision making were not indicated.

A progress note, dated April 29, 2022 at 5:50 p.m., indicated the Executive Director was notified by a physical therapist Resident E had been found unsupervised and outside on the patio of another resident's room.

The physical therapist who had observed Resident E was interviewed on June 13, 2022 at 10:00 a.m. During the interview the therapist indicated on April

Elopement policy and procedure, including but not limited to keeping memory care doors secured at all times.

4.
How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

The ED, DNS, and MCS will review Resident Service Plans Monday – Friday during the CQI Meeting prior to the morning department meetings. The CQI meetings are ongoing. An Elopement monitoring tool will be completed weekly x 4 weeks then monthly x 3 months. If 100% threshold not met, disciplinary action and new action plan will be completed. The monitoring tool will be completed by Executive Director/Director of Nursing or designee.

29, she had provided therapy services to a resident who resided in an Assisted Living Apartment. The therapy services included outdoor walking. Upon having exited the other resident's apartment the therapist observed Resident E "alone outside." "I was kinda shocked" to have seen him. The therapist tried to converse with Resident E, but he was "just confused and mumbled." After the interview, the therapist was observed to walk the potential path Resident E had taken from Memory Care 1 (MC1) to the Assisted Living Apartment. The path resembled a capital F. The first door, exit from MC1 neighborhood could not be opened without having entered a code into a keypad that allowed for exit. Once exited from MC1 was a foyer area and a second exit door to the outside. The second door also required an entered code into a keypad that allowed for exit. Once outside one would be standing on the right side of the capital F's top crossbar. From there one would walk from the right to the left side of the F's top crossbar, then one would turn the corner and begin to walk down from the F's leg top toward the bottom the F's leg. At the F's lower crossbar was a service road that one would need to cross to reach the lower leg of the F, or the assisted living apartment Resident E had

	walked to. On June 13, 2022 at 10:30 a.m. the Executive Director was interviewed. During the interview, the Director indicated on April 29, 2022 a new resident was moving into the memory care neighborhood. The facility's investigation indicated during the move in time frame Employee 1 had propped open MC1 exit door and did not remain in the area during the time the door was propped open. Employee 1's employment was terminated related to their actions. Employee 2 had turned the keypad off with a master code to the foyer exit to the outside and did not remain in the area during the time the door was not secured. Employee 2 received written discipline related to their actions. This State Residential Finding relates to Complaint IN00379118.			

Based on interview and record review, the facility failed to ensure a resident assessed to require a secure neighborhood did not independently exit the neighborhood through 2 unsecured and unsupervised exit doors for 1 of 2 residents reviewed for elopement risk in a sample of 6 residents reviewed for implementation of service plan. (Resident E)

Findings include:

Resident E's clinical records were reviewed on June 10, 2022 at 11:50 a.m. Diagnoses included, but were not limited to, Parkinson's disease and other involuntary movements, dementia with Lewy bodies, vascular dementia with behavioral disturbances, unspecified disorientation, and unsteadiness on feet with other abnormalities of gait and mobility.

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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 PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE