STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE OF CARMEL	689 PRO MED LANE, CARMEL, , 46032

(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 IN00371698 and IN00372158. Complaint IN00371698 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00372158 - Substantiated. State deficiencies related to the allegations are cited at R52. Survey dates: February 8 and 9, 2022 Facility number: 013510 Residential Census: 75 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 18, 2022.	R 0000		
R 0052	Residents' Rights - Offense	R 0052	What corrective action(s) will be accomplished for those residents	03/15/2022

	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, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia who was assessed to be at risk for elopement, was free from neglect when she wandered away from the facility without the facility staff's knowledge, for 1 of 3 residents reviewed for neglect (Resident B). Resident B who was confused eloped from the facility on 01/28/2022 at 10:15 a.m., dressed only in a zip-up hoodie during a snowstorm with the temperature at 22 degrees, ambulating between the garages and ambulating down a four (4) lane highway before being picked up by the local fire and EMS and eventually arriving at the local hospital. Findings include: During an interview, on 02/08/2022 at 9:42 a.m., the		found to have been affected by the deficient ¿¿¿Licensed nurses will timely conduct change of condition assessments to determine any change in elopement risk. Resident B was assessed upon return to the community and found to be at for elopement. The resident's family provided 1:1 oversight until the resident was transferred to memory care on 1/31/2022. ¿¿-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be ¿All assisted living residents currently assessed at Low Risk for elopement will be reassessed for elopement risk by 3/15/22. All community licensed nurses, caregivers, and qualified medication assistants received retraining on change of condition policies and procedures to include changes of condition alerting and assessment requirements by 3/15/22.¿-What measures will be put into place or what systemic changes make to ensure that the deficient practice does not ¿All community licensed nurses, caregivers, and qualified medication assistants received retraining on change of condition associated policies and procedures to include changes of condition alerting and assessment requirements by 3/11/2022. Training on missing residents and elopement policy and procedures and missing person drills will be conducted for all team members by 3/11/22 and quarterly thereafter. -How the corrective action(s) will	

	Executive Director (ED) indicated the facility had received a call from the local hospital emergency room "around noon" on 01/28/2022 notifying the facility Resident B had been found walking at "a roundabout" at 136th street near US highway 31 and had been taken to the emergency room for treatment. The ED indicated, upon interviewing staff regarding the event, the resident was last seen on 01/28/2022 at 9:30 a.m., when a QMA (qualified medication aide) had administered her morning medications. The ED stated she had reviewed the monitoring cameras and observed the resident had walked out the west side exit door at 10:51 a.m., on 01/28/2022, ambulating between the garages until out of site of the camera. Resident B was observed, in her room, on the locked memory care unit on 02/08/2022 at 12:32 p.m. The resident was found seated on a couch and dressed appropriately for the day. Resident B was smiling and pleasant during the observation but appeared to be anxious, wringing her hands and placing her hands over her face, rocking back and forth, stating she didn't "want to go out there with those women" and speaking about a "baby" which needed to be taken care of. During the interview, the		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and¿Change of conditions will be monitored in daily stand-up meetings, and weekly leadership meetings with a licensed community clinician. Missing and elopements will be reviewed in monthly QAIP to ensure proper training and education is provided to team members.	

resident was unable to state her name, her date of birth, where she was or if she had eaten lunch. The resident had great difficulty putting together meaningful sentences and spoke often with jumbled words with no meaning. She did not initiate conversation but attempted to answer when spoken to. On a coffee table, in front of the resident, were several coloring books and an open bowl type container holding a multitude of colored pencils. Resident B was unable to name the color of an orange pencil however pulled out 3 additional pencils of the same color. Many pictures were observed on a side counter in the room which appeared to be of family and friends. When asked, Resident B was unable to identify any of the people in the pictures, but smiled and said they were "nice people."

The record for Resident B was reviewed on 02/08/2022 at 1:13 p.m. Diagnosis included, but were not limited to, dementia without behavioral disturbance, asthma, osteoporosis and hypertension. The clinical record indicated the resident had initially been admitted to the facility on 08/13/2021. Her room was on the first floor at the end of a long hall, with the exit door approximately fifteen (15) feet from her apartment.

Progress notes indicated the following:

On 08/13/2021 at 5:14 p.m., "...pendant given to (resident's name) and education provided on its use. Education also provided on use of pull cord lights in apartment...has short term memory loss. Will need reminders for ADLs (activities of daily living) and meals."

On 08/23/2021 at 4:44 a.m., "resident noted wandering in parking lot by cna (certified nursing assistant). Noted carrying purse and some personal clothing. confusion noted. Resident unable to give writer her full name or room number. Stated she was looking for her daughter's vehicle because she was ready to go..."

On 12/17/2021 at 11:09 a.m., "CNA reported increased confusion, res (resident) unintentionally unable to follow simple commands...."

On 12/19/2021 at 10:43 a.m., "res locked self out of apt (apartment) after forgetting to bring key...."

On 12/23/2021 at 11:56 a.m., "res could not get back into apt after forgetting key...."

On 12/23/2021 at 12:01 p.m., "res required staff escort to and from Beauty salon today"

On 01/01/2022 at 2:01 p.m., "CNA reported res has not eaten her breakfast or lunch and that the food was just sitting on the counter. Writer instructed CNA to reheat and set up meal placement for res and let res know its ready. Writer entered res room after 20 min (minutes) and food was still sitting in front of res. Res stated that she already ate her lunch however food remained untouched. Writer asked if she would like something else to eat. res stated no. writer insisted res eat something at this time. res stated 'ok' but did not touch food...."

On 01/02/2022 at 11:09 a.m., "...cont (continue) to have low appetite...noticed res packing breakfast back into bag untouched...res confused and not able to follow simple instruction at this time. will cont to monitor...."

On 01/07/2022 at 3:39 p.m., "CNA reported res hiding food in odd places throughout room and that moldy food was found inside drawers and in books...."

On 01/14/2022 at 3:27 p.m., "Resident beginning to have memory problem, forgetting where her room is located. Resident was on the 2nd floor wandering around until she saw another resident who brought resident to the nursing station.

Resident was looking for her room on the 2nd floor when she live (sic) on the 1st floor. CNA escorted resident back to the 1st floor to her room. Will continue to monitor and assist resident with her needs."

On 01/16/2022 at 5:43 p.m., "CNA reported res refusing food that is set in front of her because 'there is no food there'. Res needing physical assistance with eating. res resisting care...."

On 01/17/2022 at 9:42 a.m., "Resident appear (sic) to have increased confusion, forgot to go to the toilet and had an incontinent episode of BM on herself. CNA was trying to shower resident but resident was refusing to get shower and changed...Resident need (sic) to be on Memory Care for more one on one care which writer informed daughter. Daughter states resident was recently diagnosed with Alzheimer's Dementia which is progressing more now."

On 01/19/2022 at 6:12 a.m., "Resident was found in room more confused than usual. Resident refused to get in bed all night. Resident refused CNA assistance, the writer assisted resident to the restroom and into pajamas, but still refused to get in bed stated she was waiting on her mom. Resident was

safety checked throughout the night. At 6:00 am med pass resident was in apartment with coat, hood and gloves on refused to remove articles. And still refused to lay down."

On 01/28/2022 at 12:15 p.m., "writer was notified resident was found outside the premise of the facility at noon. resident was sent to ER for eval. ED notified of incident"

A review of the resident's Elopement Risk Evaluations indicated the following:

On 08/13/2021, the resident scored a "3" and was deemed to be a "low risk"

On 08/24/2021, the resident scored a "5" and was deemed to be a "high risk" The evaluation stated the "Resident did go out front door unobserved by staff in the early morning"

On 01/24/2022, the resident scored a "2" and was deemed to be a "low risk"

On 01/27/2022, the resident scored a "3" and was deemed to be a "low risk"

Review of the elopement risk evaluations, dated 01/24/2022 and 01/27/2022, indicated the resident did not have a diagnosis of dementia as stated on the resident's diagnosis sheet which may have

increased her score.

A BIMS (Brief Interview for Mental Status) assessment, dated 08/12/2021, and described as "admission" on the assessment form, indicated the resident scored a "2" A score between 0 - 7 would indicate a severely impaired cognition.

The resident's current Service Plan, dated 08/30/2021, indicated "Focus: Cognition...Goal: Needs prompts and cues at times...Interventions: Elopement Risk: Resident woke on evening confused looking for her daughter. MD (doctor) stated confusion likely because of adjusting to new surroundings."

Documentation obtained from the local hospital, on 02/09/2022 at 12:12 p.m., indicated the following:

EMS (emergency medical services) documented indicated on 01/28/2022 at 3:58 p.m., "...found the pt (patient) walking down the middle of the roadway on US 31 @ (at) 136th street. The staff member believing the pt just needed a ride, picked the pt up and brought her to station (number of station). The pt appeared to be a 70 yof (year old female) wearing a zip-up hoodie as a shirt, jeans, and thin cloth shoes in a heavy snowstorm @ 22 degrees. Pt

was cold to touch, socially conversive but unable to relay her birthdate, last name...Pt was carrying a purse which gave EMS her name, and insurance card but no DOB (date of birth)...Pt was cold to touch...Pt was allowed to sit in chair for a few minutes and warm. Pt mental status did not change or improve with warmth...(local police department) was contacted and agreed to meet EMS at ED (emergency department). Initiated and transported to closest ED ...".

Hospital ED documented on 01/28/2022 at 11:29 a.m., "Patient 77 year-old female who presents to the emergency department with altered mental status. The patient was found walking on 31 without a coat on in the snow. Patient was actually picked up by (local fire department) as they were going to give her a ride to wherever she needed to go, but upon them getting a history, the patient was unable to tell us her name, her birthdate, or names of any family members. (name of police department) arrived in the ER (emergency room) with the patient. The patient did come the ER with a purse. We obtained the patient's name from paperwork that was on her purse, there was a card from a physician's office that we were able to contact and get a phone number for family...Patient is a

(sic) apparently in assisted living at (the facility) per family when we were able to contact them...."

In a statement, provided by the ED on 02/09/2022 at 4:12 p.m., the family and Resident B arrived at the facility on 01/28/2022 at 2:36 p.m., at which time the ED met with the family and assisted the family and resident to tour the memory care unit. The family took the resident home at that time to provide the resident with one-on-one supervision until her readmission to the facility's memory care unit on 01/31/2022.

A current facility policy, titled "Missing Residents and Elopement," dated as last updated on 01/04/2022 and provided by the ED on 02/09/2022 at 4:06 p.m., indicated "...Elopement occurs when a resident incapable of taking appropriate action for self-preservation leaves the Community's premises or a safe area without the Community's knowledge (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so...To assist in the prevention of resident elopement: 1. Upon move in and changes in condition, a registered nurse will assess the resident for being incapable of taking appropriate action for

self-preservation under emergency conditions or at risk for wandering or elopement using the Community's Comprehensive Assessment a. If the assessment indicated that the resident is ...at risk for wandering or elopement, interventions will be added to the resident's care/service plan b. The assessment results will be discussed with the resident's legal representative as warranted...."

This State Tag relates to Complaint IN00372158.

Based on observation, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia who was assessed to be at risk for elopement, was free from neglect when she wandered away from the facility without the facility staff's knowledge, for 1 of 3 residents reviewed for neglect (Resident B). Resident B who was confused eloped from the facility on 01/28/2022 at 10:15 a.m., dressed only in a zip-up hoodie during a snowstorm with the temperature at 22 degrees, ambulating between the garages and ambulating down a four (4) lane highway before being picked up by the local fire and EMS and eventually arriving at the local hospital.

Findings include:

During an interview, on 02/08/2022 at 9:42 a.m., the Executive Director (ED) indicated the facility had received a call from the local hospital emergency room "around noon" on 01/28/2022 notifying the facility Resident B had been found walking at "a roundabout" at 136th street near US highway 31 and had been taken to the emergency room for treatment. The ED indicated, upon interviewing staff regarding the event, the resident was last seen on 01/28/2022 at 9:30 a.m., when a QMA (qualified medication aide) had administered her morning medications. The ED stated she had reviewed the monitoring cameras and observed the resident had walked out the west side exit door at 10:51 a.m., on 01/28/2022, ambulating between the garages until out of site of the camera.

Resident B was observed, in her room, on the locked memory care unit on 02/08/2022 at 12:32 p.m. The resident was found seated on a couch and dressed appropriately for the day. Resident B was smiling and pleasant during the observation but appeared to be anxious, wringing her hands and placing her hands over her face, rocking back and forth, stating she didn't "want to go out there

with those women" and speaking about a "baby" which needed to be taken care of. During the interview, the resident was unable to state her name, her date of birth, where she was or if she had eaten lunch. The resident had great difficulty putting together meaningful sentences and spoke often with jumbled words with no meaning. She did not initiate conversation but attempted to answer when spoken to. On a coffee table, in front of the resident, were several coloring books and an open bowl type container holding a multitude of colored pencils. Resident B was unable to name the color of an orange pencil however pulled out 3 additional pencils of the same color. Many pictures were observed on a side counter in the room which appeared to be of family and friends. When asked, Resident B was unable to identify any of the people in the pictures, but smiled and said they were "nice people."

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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