

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2022
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF LEBANON		STREET ADDRESS, CITY, STATE, ZIP CODE 610 CROWNPOINTE DRIVE, LEBANON, , 46052			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00390245. Complaint IN00390245 - Substantiated. State deficiencies related to the allegations are cited at R52. Survey date: September 22, 2022 Facility number: 013582 Residential Census: 49 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 29, 2022.	R 0000	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	R 052	10/18/2022	
			1.) Resident B was admitted on 10/26/2016, since her admission Resident B has never		

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- (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, was free from neglect when she wandered away from the facility grounds and walked across State Road 39, without the facility staff's knowledge, for 1 of 3 residents being reviewed for neglect. (Resident B) Resident B was found 0.2 miles from the facility and her location was unknown for approximately 30 minutes.

Finding includes:

During a walk-through of the facility with LPN 1, on 09/22/22 beginning at 1:19 p.m., a camera was found in the main lobby, pointed at the front door. Cameras were also found pointed at the doors located at an alarmed exit by room 120, the dining room exit, an alarmed exit which opened to the east parking lot, an exit which opened to a courtyard between rooms 131 and 133, and an exit by room 136. During the

exhibited wandering behaviors outside of facility grounds, Resident B has been re-located to a more appropriate facility on 9/21/2022.

2.) All residents have the potential to be affected. All residents will be re-assessed for elopement risk to ensure continued resident safety. The facility policy will be followed as deemed necessary.

Prior to resident B walking over to the apartment complex, all Elopement Risk Assessments had no history of wandering. Resident B enjoyed the outside, would sit out front on bench, out back on patio and loved to walk around the outside of facility. Resident B has never exhibited exit seeking behaviors nor did resident B previously exit facility leaving facility grounds prior to going to the apartment complex.

3.) All staff will be re-educated on Resident Rights and how/when to report cognitive changes, a re-assessment will be completed on any/all cognitive changes and

walk-through, LPN 1 indicated she thought the resident exited the building from the main entrance.

The record for Resident B was reviewed on 09/22/22 at 10:05 a.m. Diagnoses included, but were not limited to, memory deficit, sundowning (a state of confusion occurring in the late afternoon and lasting into the night) and dementia.

A nurse's note, dated 09/14/22 at 8:30 a.m., indicated the resident exited the facility on 09/13/22 between 6:45 p.m. and 7:00 p.m. She returned to the facility at 7:40 p.m.

A facility document, titled "ELOPEMENT RISK ASSESSMENT," indicated on July 07, 2022, the resident was cognitively impaired with poor decision making, the resident had a pertinent diagnosis (i.e. Dementia, OBS, Alzheimer's, Delusions, Hallucinations, Anxiety Disorder, Manic Depression, Schizophrenia), ambulated independently, and had a history of wandering per the family or responsible party.

A facility document, titled "ACCIDENT/INCIDENT REPORT," provided by the Executive Director on September 22, 2022 at 10:23 a.m., indicated, on 09/13/22 at 7:20 p.m., an officer arrived at

quarterly. Facility has installed Stanley Healthcare Security, a new pendant system that will alarm every 15 minutes should a resident go further than 150 feet from facility. Every resident has a pendant which they wear at all times.

4.) All resident Elopement Risk Assessment reviewed and updated. Elopement assessments are completed every 3 months, unless cognitive charges are noted prior, and upon re-admissions and new admissions. Health and Service Director will report any concerns to the Quality Assurance Committee and will follow recommendations to ensure compliance. Our Corporate Nurse/Infection Preventionist will audit monthly (X6 months) all elopement assessments to ensure accuracy and on-going compliance.

5.) Date: 10/18/2022

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the facility at 7:20 p.m., and showed a picture on his cell phone of Resident B and asked if she lived at the facility. The officer was advised Resident B did live at the facility and her name was provided to the officer. The officer indicated someone found her across the road and asked if someone could go and get her. CNA 3 walked across State Road 39 to locate Resident B. CNA 3 was able to locate the resident. The form had been signed by QMA 2.

During a telephone interview, on 09/22/22 at 9:45 a.m., Resident B's family member indicated she received a call about 6:30 p.m., informing her Resident B was "pretty confused". The resident did have a urinary tract infection and dementia. She was later informed the resident was found sitting on a bench in a housing complex across State Road 39. A woman found the resident and contacted the police.

During a telephone interview, on 09/22/22 at 9:49 a.m., another family member of Resident B indicated she received a phone call informing her the resident had walked across the road (State Road 39) and was found sitting on a bench in a housing addition.

During a telephone interview, on 09/22/22 at 10:39 a.m., CNA 3

indicated she was not aware the resident had left the facility until she was called to the first floor. She indicated the police were at the facility and informed the facility Resident B was found in the housing complex and requested if staff could retrieve the resident. CNA 3 left the facility on foot, crossed State Road 39, walked to the housing area, and found the resident at the first apartment on the left. She indicated the woman which lived in the apartment took them back to the facility. She did not know the woman. The last time she observed the resident in the facility was about 6:40 p.m., and the next time she observed the resident was about 7:20 p.m., when she arrived at the housing complex. CNA 3 indicated there were too many doors to watch, the doors are locked to prevent anyone from entering the building, but not locked to prevent anyone from leaving the building. CNA 3 indicated, at the time the resident exited the building, there were two staff members, herself and the QMA.

During an interview, on 09/22/22 at 1:31 p.m., the Executive Director indicated the resident probably exited the building via the front exit, but she was not here so she was not sure. Resident B liked to go outside and sit on the benches out front. She did not review the camera footage at the exits, as she

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could not get them to back up. Sometimes the activity staff member could get it to work, sometimes they worked sometimes they did not. She did not think it was a camera issue but an internet issue in the city.

An attempt to contact the QMA which was on duty September 13, 2022 was made on September 22, 2022 at 11:00 a.m., and again at 1:57 p.m. A message indicated the mail box was full on both occasions.

A facility policy, titled "ABUSE POLICY," dated revised on 07/19 and provided by LPN 1 on September 22, 2022 at 1:15 p.m., indicated "...Neglect...Any...action or lack of action that you have a duty to perform and your failure to act could result negatively affect the resident's health, safety or welfare...."

This State finding relates to Complaint IN00390245.

Based on observation, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia, was free from neglect when she wandered away from the facility grounds and walked across State Road 39, without the facility staff's knowledge, for 1 of 3 residents being reviewed for neglect. (Resident B) Resident B was found 0.2 miles from the

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FORM APPROVED

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OMB NO. 0938-0391

could result negatively affect the resident's health, safety or welfare...."

This State finding relates to Complaint IN00390245.

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