

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 03/31/2026	
NAME OF PROVIDER OR SUPPLIER HI JILL'S HOUSE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 751 E TAMARACK TRAIL, BLOOMINGTON, , 47408					
(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 Intake 468833. Intake 468833 - State deficiencies related to the allegations are cited at R52. Survey date: March 31, 2026 Facility number: 013824 Residential Census: 17 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April 2, 2026.	R 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective April 15, 2026. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC and supporting documents submitted.				
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	1. Corrective action(s) for the resident(s) affected • Resident B was assessed upon return for injury, distress,		04/15/2026		

- (2) physical abuse;
- (3) mental abuse;
- (4) corporal punishment;
- (5) neglect; and
- (6) involuntary seclusion.

Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 3 residents reviewed for elopement. This deficient practice resulted in staff not responding to an exit door alarm and a cognitively impaired resident exited the building without staff knowledge.
(Resident B)

Findings include:

On 3/31/26 at 11:00 a.m., Resident B's clinical record was reviewed. The diagnosis included, but was not limited to, Alzheimer's Disease.

The Service Function Evaluation, dated 2/12/26, indicated Resident B's ambulation and physical ability was independent, up ad lib (Latin phrase ad libitum, meaning "at pleasure" or "as much as one desires"), and gait steady. Resident B's cognition assessment indicated the resident was disoriented to time and place, the resident cannot

and change in condition. No injury was identified.

- Resident B was placed on 15-minute safety checks beginning 3/22/26 through 3/26/26.
- Family and Primary Care Provider were notified.

- Stops Signs were placed across emergency doors to deter residents.
- Resident B's care plan was updated to include enhanced supervision and monitoring interventions related to exit-seeking behaviors.

2. How the facility will identify other residents potentially affected

- All residents were identified as potentially affected.
- All resident at risk were immediately placed on additional interventions including increased supervision, staff awareness alerts, and individualized care plan updates.

3. Systemic changes to ensure the deficient

make decisions regarding health and safety. Resident had short term and long term memory impairment. Resident B was noted to have no activity of wandering.

The Risk of Elopement/Wandering Review, dated 2/12/26 indicated no risk of elopement.

A Progress Note, dated 3/22/26, indicated the resident exited through the emergency exit door in the stairwell. Staff checked interior of building, Director of Operations/HFA (Health Facility Administrator), Wellness Director, and 911 were notified. Police arrived with the resident, resident assessed and had no signs or symptoms of distress, the resident was at baseline for confusion, short term memory, and long term memory. Family and Primary Care Provider were notified by the facility and the resident was placed on 15 minute checks starting on 3/22/26 and continuing through 3/26/26.

The Exit Seeking Event, dated 3/23/26, indicated Resident B was last observed visiting with other residents, at approximately 7:00 p.m., in the community living room. Staff became aware of the resident's absence during rounds. A search of the immediate area was initiated. The resident was

practice does not recur

- The facility revised and re-educated staff on the Exit Alarm Response Policy, requiring:
 - Immediate response to all exit door alarms.
 - Immediate visual check of the exit door area.
 - Immediate head count of residents when alarm sounds.
 - Immediate notification of the nurse/shift lead and Administrator on-call if resident cannot be located.
- Staff will no longer assume an alarm is false or caused by staff without confirming the door is secure and resident location is verified.
- The facility implemented mandatory documentation requirements for all alarms including time alarm sounded, response time, actions taken, and resident verification.
- The staff member involved was removed from schedule pending investigation and appropriate personnel action was taken per facility policy.
- Maintenance reviewed exit doors/alarms to ensure proper functioning and latching. Routine alarm checks were implemented.

4. How the facility

located at a near by residence and returned to the community by a police officer without injury.

On 3/31/26 at 11:35 a.m., the Administrator provided a written statement from CNA (Certified Nurse Aide) 1. The statement indicated on 3/22/26 at 7:00 p.m., CNA 1 heard the sound of an alarm. At 7:20 p.m., the alarm was still sounding, CNA 1 noticed the emergency exit door was not latched properly and she properly latched the door. CNA 1 indicated she alerted the nurse the emergency exit door was not latched and the alarm was still sounding. She indicated there was no action taken by the nurse at that time. At 9:00 p.m., CNA 1 was notified by the nurse that Resident B was missing. At 9:20 p.m., CNA 1 observed the nurse walking back into the facility and a police patrol car following with Resident B present.

During an interview on 3/31/26 at 11:40 a.m., the Administrator indicated that Resident B exited the facility through an emergency exit door, she indicated that an alarm was noted on 3/22/26 at approximately 7:00 p.m. by the CNA working. She indicated that the nurse working that night was made aware of the alarm at approximately 7:20 p.m., and an immediate head count of

will monitor corrective actions (QA/QAPI)

- The Administrator or designee will conduct audits of:
 - Alarm response documentation logs
 - Resident head count completion
 - Care plan updates for residents identified at risk
- Audits will occur weekly for 4 weeks, then monthly for 5 months.
- Any failure to follow alarm response protocol will result in immediate re-education and corrective action.
- Audit results will be reviewed during the facility's Quality Assurance/Performance Improvement (QAPI) meetings and maintained as documentation of compliance.

5. Completion date

All corrective actions, staff education, resident re-assessments, and implementation of monitoring audits will be completed by: 04/15/2026.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

residents was not performed. The Administrator indicated that it was approximately one and a half hours after the alarm started before a head count was initiated. She indicated at that time it was noted that Resident B was missing. The Administrator indicated Resident B was located at a nearby residence by the police and returned to the facility unharmed. The HFA indicated it was the policy of the facility that if an alarm had sounded, an immediate head count of all residents was to be initiated, she indicated this was not done on the night of the elopement event.

This citation relates to Intake 468833.

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
SIGNATURETeresa

TITLEGlidden

(X6) DATE04/15/2026