STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMONS ON MERIDIAN, THE	8549 N MERIDIAN STREET, INDIANAPOLIS, , 46260

(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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00358162. Complaint IN00358162- Substantiated. State deficiencies related to the allegation are cited at R0052. Survey dates: July 20 and 21, 2021 Facility number: 013933 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 23, 2021.	R 0000	**The creation and submission of this Plan of Corrections does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.**	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be	R 0052	**R 052 – Residents' Rights**	08/05/2021

	free from: (1) sexual abuse; (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 ensure a resident with dementia was free from neglect when he wandered, unnoticed, from the facility grounds, walked down 86th Street, crossed 86th Street and was found at the bank 0.8 miles from the facility for 1 of 3 residents reviewed for neglect (Resident B). This deficient practice resulted in Resident B requiring staff to leave the facility and pick the resident up and transport him back to the facility. Findings include: During an interview, on 07/20/21 at 11:40 a.m., Resident B was not able to recall which door he had exited from on 07/13/21 and had difficulty remembering the event.		**Offense. The facility must establish and maintain a practice designed to provide an free of abuse and neglect.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ***Education was provided to the team members regarding the need to report changes in resident condition, such as risk for elopement, change in mental status or danger to self and others to the Director of Health and Wellness and/or designee.*** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ***All residents have the***	

	The record for Resident B was reviewed on 07/20/21 at 1:45 p.m. Diagnoses included, but were not limited to, Dementia with Lewy Bodies (a type of progressive dementia which leads to a decline in thinking, reasoning and independent function), depression and hypertension. The Service Plan for Resident B, dated 05/20/21, indicated "...No wandering issues...Resident does not have current or history of wandering...." A nursing note, dated 2/11/2021 at 5:46 p.m., indicated "... Resident very agitated and looking for away to get out of the community to go be with his wife...." A nursing note, dated 2/11/2021 at 5:46 p.m., titled "Late Entry BOM (Business Office Manager) report DHW(Director of Health and Wellness/Director of Nursing)...resident in her office 5 times in an hour once he said he wanted to kill himself expressed wanting to get out of this place to be with (spouse)...." A nursing note, dated 02/23/21 at 1:40 p.m., indicated a staff member received a call from (name of facility), "...Nurse explains he needs to continue to be on a secured unit as he is at		***potential to be affected by this deficient practice.*** **What measures will be put int place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ***The Director of Health and Wellness and the Director of Virtue (Memory Care) have been educated to complete a change of condition assessment and update the service plan with each change in condition to reflect resident needs.*** ***An elopement risk assessment will be conducted during the change of condition assessment. The service plan will be updated with the interventions such as placing a Wander Guard bracelet.*** ***The Elopement Risk binder will be updated with each resident identified as being an elopement risk. The binder contains a picture and the risk factors for each resident.*** ***The Primary Care Physician***	

	risk for elopement...." A nursing note, dated 07/06/21 at 8:56 p.m., indicated a staff member observed Resident B outside by the door. When the staff member opened the door and asked Resident B why he was outside, he was not able to "...get his thoughts together as to why he was outside...Resident stated he was turned around and that he was in the parking lot at the union waiting to be picked up from his wife...." A nursing note, dated 07/12/21 at 5:49 a.m., indicated "...Resident restless and confused all night. He did not try to elope but he continued to walk the halls looking for a man with a truck...." A document, titled "Indiana State Department of Health Survey Report System," dated July 13, 2021, indicated "...Incident Date: 07/13/21...Incident time: 08:45 p.m....Description...Resident left the community without notification of the nursing team...." A statement provided by the Director of Nursing on 07/20/21 at 3:07 p.m., indicated QMA 2 received a call from QMA 3, indicating Resident B was observed walking down 86th Street. Both QMAs left the		***will be contacted to assess the resident for placement in Memory Care.*** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.,** ***The Director of Health and Wellness and/or designee will review clinical documentation daily for awareness of potential changes in condition. If a change in condition is identified, the Director of Health and Wellness and/or designee will complete a change in condition assessment and the service plan will be updated to reflect resident needs.*** ***Daily observation of the Wander Guard device for placement as well as function to ensure safety.***	

	facility to find the resident. The resident was located at a bank on 86th Street and College. They assisted the resident into the car. The resident had used "foul" language and stated he wanted to kill himself. During an interview, on 07/20/21 at 2:20 p.m., Kitchen Staff 1 indicated at approximately 9:00 p.m., on July 13, 2021, he observed a person which looked like a resident on 86th Street and College Avenue. He was on the south side of 86th Street. He realized it was a resident and contacted the facility to alert them. Staff at the facility informed Kitchen Staff 1, Resident B was in bed. He indicated facility staff was unaware the resident was not in the facility. He then contacted the Activity Director and informed him of his observation of Resident B on the road. Kitchen Staff 1 indicated he did not stay with the resident as he was in his car, traveling with his children, on the road when he observed Resident B on 86th Street and College Avenue. During an interview, on 07/20/21 at 2:33 p.m., the Activities Director indicated he received a call from Kitchen Staff 1 informing him a resident had been seen on 86th Street. The staff member reported Resident B's location, and the Activity Director requested the staff		**What date the systemic changes will be completed.** **8-5-2021**	

	member remain with the resident, but the staff member was in a car, had passed the resident and was unable to stay with him. The Activities Director indicated nursing staff picked up the resident. During an interview, on 07/20/21 at 3:06 p.m., the Director of Nursing indicated she received a call a little after 9:00 p.m., informing her Resident B was observed on 86th Street. While driving to the facility, she contacted another staff member and the Nurse Practitioner. She indicated she did not pick up the resident, QMA 2 retrieved him. She indicated upon Resident B's return he was very irritated, no injuries were observed, he refused to allow a vital sign assessment and was sent out to the Emergency Room for further evaluation. During an interview, on 07/20/21 at 3:21 p.m., QMA 2 indicated she received a call an employee saw Resident B on 86th Street. She got into her car to go retrieve the resident. He was found at a bank on the north east side of College Avenue and 86th Street. He did not appear to have sustained any injuries, but he was not himself and seemed more confused. She indicated she asked Resident B why he left the facility and informed him of the dangers to which he replied, to			

	her, he did not care and he wanted to kill himself. During an interview, on 07/21/21 at 11:32 a.m., the Director of Nursing indicated QMA 3 was the staff member who received the initial call to report Resident B was out of the facility. No one knew the resident had left the building and believed he left through the front/main entrance. She indicated there was no receptionist/staff coverage after 8:00 p.m. until 8:00 a.m. The main entrance was locked to anyone trying to enter the facility, but it was not locked for anyone exiting the building. She further indicated there were no cameras in the facility to show the resident's exit. She did not feel the resident was an elopement risk, prior to the event and did not do an elopement assessment. The matter was discussed with the family, prior to the event, and the family did not want the resident on a secured unit.			

	During an interview, on 07/21/21 at 2:59 p.m., QMA 3 indicated she had not been aware Resident B had exited the building until she received the phone call informing her the resident was observed on the road. She left with QMA 2 to pick up the resident and return him to the facility. He was located on 86th Street and College Avenue at the bank. An undated facility policy, titled "Elopement Resource Manual," provided by the Director of Nursing on 07/20/21 at 3:07 p.m., indicated "...Once resident if found...Document...ensuring the resident's care/service plan has been updated...with interventions to prevent or decrease the risk of future elopements...." This State Finding related to Complaint IN00358162. Based on interview and record review, the facility failed to ensure a resident with dementia was free from neglect when he wandered, unnoticed, from the facility grounds, walked down 86th Street, crossed 86th Street and was found at the bank 0.8 miles from the facility for 1 of 3 residents reviewed for neglect (Resident B). This deficient practice resulted in Resident B requiring staff to leave the facility and pick the resident up and transport him back to the			

facility.

Findings include:

During an interview, on 07/20/21 at 11:40 a.m., Resident B was not able to recall which door he had exited from on 07/13/21 and had difficulty remembering the event.

The record for Resident B was reviewed on 07/20/21 at 1:45 p.m. Diagnoses included, but were not limited to, Dementia with Lewy Bodies (a type of progressive dementia which leads to a decline in thinking, reasoning and independent function), depression and hypertension.

The Service Plan for Resident B, dated 05/20/21, indicated "...No wandering issues...Resident does not have current or history of wandering...."

A nursing note, dated 2/11/2021 at 5:46 p.m., indicated "... Resident very agitated and looking for away to get out of the community to go be with his wife...."

A nursing note, dated 2/11/2021 at 5:46 p.m., titled "Late Entry BOM (Business Office Manager) report DHW(Director of Health and Wellness/Director of Nursing)...resident in her office 5 times in an hour once he said he wanted to kill himself

	expressed wanting to get out of this place to be with (spouse)...." A nursing note, dated 02/23/21 at 1:40 p.m., indicated a staff member received a call from (name of facility), "...Nurse explains he needs to continue to be on a secured unit as he is at risk for elopement...." A nursing note, dated 07/06/21 at 8:56 p.m., indicated a staff member observed Resident B outside by the door. When the staff member opened the door and asked Resident B why he was outside, he was not able to "...get his thoughts together as to why he was outside...Resident stated he was turned around and that he was in the parking lot at the union waiting to be picked up from his wife...." A nursing note, dated 07/12/21 at 5:49 a.m., indicated "...Resident restless and confused all night. He did not try to elope but he continued to walk the halls looking for a man with a truck...." A document, titled "Indiana State Department of Health Survey Report System," dated July 13, 2021, indicated "...Incident Date: 07/13/21...Incident time: 08:45 p.m....Description...Resident left the community without			

	notification of the nursing team...." A statement provided by the Director of Nursing on 07/20/21 at 3:07 p.m., indicated QMA 2 received a call from QMA 3, indicating Resident B was observed walking down 86th Street. Both QMAs left the facility to find the resident. The resident was located at a bank on 86th Street and College. They assisted the resident into the car. The resident had used "foul" language and stated he wanted to kill himself.			

	During an interview, on 07/20/21 at 2:20 p.m., Kitchen Staff 1 indicated at approximately 9:00 p.m., on July 13, 2021, he observed a person which looked like a resident on 86th Street and College Avenue. He was on the south side of 86th Street. He realized it was a resident and contacted the facility to alert them. Staff at the facility informed Kitchen Staff 1, Resident B was in bed. He indicated facility staff was unaware the resident was not in the facility. He then contacted the Activity Director and informed him of his observation of Resident B on the road. Kitchen Staff 1 indicated he did not stay with the resident as he was in his car, traveling with his children, on the road when he observed Resident B on 86th Street and College Avenue. During an interview, on 07/20/21 at 2:33 p.m., the Activities Director indicated he received a call from Kitchen Staff 1 informing him a resident had been seen on 86th Street. The staff member reported Resident B's location, and the Activity Director requested the staff member remain with the resident, but the staff member was in a car, had passed the resident and was unable to stay with him. The Activities Director indicated nursing staff picked up the resident.			

	During an interview, on 07/20/21 at 3:06 p.m., the Director of Nursing indicated she received a call a little after 9:00 p.m., informing her Resident B was observed on 86th Street. While driving to the facility, she contacted another staff member and the Nurse Practitioner. She indicated she did not pick up the resident, QMA 2 retrieved him. She indicated upon Resident B's return he was very irritated, no injuries were observed, he refused to allow a vital sign assessment and was sent out to the Emergency Room for further evaluation. During an interview, on 07/20/21 at 3:21 p.m., QMA 2 indicated she received a call an employee saw Resident B on 86th Street. She got into her car to go retrieve the resident. He was found at a bank on the north east side of College Avenue and 86th Street. He did not appear to have sustained any injuries, but he was not himself and seemed more confused. She indicated she asked Resident B why he left the facility and informed him of the dangers to which he replied, to her, he did not care and he wanted to kill himself. During an interview, on 07/21/21 at 11:32 a.m., the Director of Nursing indicated QMA 3 was the staff member who received the initial call to report Resident			

	B was out of the facility. No one knew the resident had left the building and believed he left through the front/main entrance. She indicated there was no receptionist/staff coverage after 8:00 p.m. until 8:00 a.m. The main entrance was locked to anyone trying to enter the facility, but it was not locked for anyone exiting the building. She further indicated there were no cameras in the facility to show the resident's exit. She did not feel the resident was an elopement risk, prior to the event and did not do an elopement assessment. The matter was discussed with the family, prior to the event, and the family did not want the resident on a secured unit. During an interview, on 07/21/21 at 2:59 p.m., QMA 3 indicated she had not been aware Resident B had exited the building until she received the phone call informing her the resident was observed on the road. She left with QMA 2 to pick up the resident and return him to the facility. He was located on 86th Street and College Avenue at the bank. An undated facility policy, titled "Elopement Resource Manual," provided by the Director of Nursing on 07/20/21 at 3:07 p.m., indicated "...Once resident if found...Document...ensuring the resident's care/service plan			

	has been updated...with interventions to prevent or decrease the risk of future elopements...." This State Finding related to Complaint IN00358162.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.	R 0117	**R 117 – Personnel Deficiency** **The facility must establish and maintain practice designed to ensure the appropriate amount of staff on duty are trained and certified in First Aid and CPR.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ***CPR/First Aid training was provided to team members. They received their certification after training.*** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	08/05/2021

	Based on interview and record review, the facility failed to ensure the appropriate amount of staff on duty were trained and certified in first aid for 13 of 21 shifts reviewed for CPR (Cardiopulmonary Resuscitation) and First Aid coverage. Findings include: During a review of staffing for the week of July 11-17, 2021 the following shifts were found to be without staff trained in First Aid: July 11, 2021- The night shift not have staff trained in First Aid on duty. July 12, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 13, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 14, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 15, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 16, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 17, 2021- The evening and		***All residents have the potential to be affected by this deficient practice.*** **What measure will be put into place ow what systemic changes the facility will make to ensure that the deficient practice does not recur;** ***CPR/First Aid training was provided to team members. They received their certification after training.*** ***The Director of Health and Wellness was provided education on the need to have staff on duty every shift with CPR/First Aid training.*** **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;**	

	night shifts did not have staff trained in First Aid on duty. During an interview, on 07/21/21 at 11:47 a.m., the Business Office Manager indicated the facility did not have all CPR and First Aid training for all staff and she had provided all the certifications she had. During an interview, on 07/21/21 at 1:32 p.m., the Director of Nursing indicated she was not aware of need to have staff on duty every shift, with CPR and First Aid training. During an interview, on 07/21/21 at 4:02 p.m., the Executive Director indicated they did not have a specific policy related to CPR/First Aid coverage and the facility follows state regulations in regards to CPR and First Aid. Based on interview and record review, the facility failed to ensure the appropriate amount of staff on duty were trained and certified in first aid for 13 of 21 shifts reviewed for CPR (Cardiopulmonary Resuscitation) and First Aid coverage. Findings include: During a review of staffing for the week of July 11-17, 2021 the following shifts were found to be without staff trained in First Aid:		***All care staff CPR/First Aid certification will be reviewed upon hire as well as annually thereafter to ensure the proper certification is in place.*** **What date the systemic changes will be completed.** **8-5-2021**	

	July 11, 2021- The night shift not have staff trained in First Aid on duty. July 12, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 13, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 14, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 15, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 16, 2021- The evening and night shifts did not have staff trained in First Aid on duty. July 17, 2021- The evening and night shifts did not have staff trained in First Aid on duty. During an interview, on 07/21/21 at 11:47 a.m., the Business Office Manager indicated the facility did not have all CPR and First Aid training for all staff and she had provided all the certifications she had. During an interview, on 07/21/21 at 1:32 p.m., the Director of Nursing indicated she was not aware of need to have staff on duty every shift, with CPR and First Aid training. During an interview, on 07/21/21			

	at 4:02 p.m., the Executive Director indicated they did not have a specific policy related to CPR/First Aid coverage and the facility follows state regulations in regards to CPR and First Aid.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed to ensure staff were wearing face masks correctly while in the facility kitchen per their policy for 3 of 3 randomly observed kitchen staff. (Kitchen Staff 4, 5 and 6) Finding includes: During an observation of the	R 0407	**R 407 – Infection Control The facility must establish and maintain an infection control practice designed to provide a safe, sanitary environment to help prevent the development and transmission of diseases and infections.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ***Education was provided to the team members on the proper way to wear PPE. The face mask should cover their mouth and nose.*** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective**	08/05/2021

kitchen on 07/20/21 at 9:18 a.m., three staff members were observed not wearing their masks to cover their mouths and noses.

During an interview, on 07/20/21 at 9:20 a.m., Kitchen Staff 4 indicated a face mask was to be on at all times while in the facility.

During an interview, on 07/20/21 at 9:21 a.m., Kitchen Staff 5 indicated staff was suppose to wear a face mask in the facility.

During an interview, on 07/20/21 at 9:23 a.m., Kitchen Staff 6 indicated a face mask was to be on at all times.

A facility policy, titled "COVID-19 Policy and Procedure," updated April 30, 2021 and provided by the Executive Director on July 21, 2021 at 2:15 p.m., indicated "...In a community without an outbreak...masks should be worn at all times by all staff...."

Based on observation, interview and record review, the facility failed to ensure staff were wearing face masks correctly while in the facility kitchen per their policy for 3 of 3 randomly observed kitchen staff. (Kitchen Staff 4, 5 and 6)

Finding includes:

During an observation of the

action will be taken;

All residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;

All team members were educated in Employee Town Hall
meeting on the proper way to wear PPE. The face mask should cover their mouth and nose.

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;

	kitchen on 07/20/21 at 9:18 a.m., three staff members were observed not wearing their masks to cover their mouths and noses. During an interview, on 07/20/21 at 9:20 a.m., Kitchen Staff 4 indicated a face mask was to be on at all times while in the facility. During an interview, on 07/20/21 at 9:21 a.m., Kitchen Staff 5 indicated staff was suppose to wear a face mask in the facility. During an interview, on 07/20/21 at 9:23 a.m., Kitchen Staff 6 indicated a face mask was to be on at all times. A facility policy, titled "COVID-19 Policy and Procedure," updated April 30, 2021 and provided by the Executive Director on July 21, 2021 at 2:15 p.m., indicated "...In a community without an outbreak...masks should be worn at all times by all staff...."		***The Director and/or designee of each department will observe their staff daily to ensure proper PPE placement. Education and subsequent progressive discipline will be provided if deficient practice is observed. The Administrator and/or designee will randomly observe staff throughout the community weekly to ensure staff have proper PPE placement and the deficient practice does not recur.*** **What date the systemic changes will be completed. 8-5-2021**	

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