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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD, GREENWOOD, , 46143

(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 IN00380975. Complaint IN00380975 - Substantiated. State Residential Findings related to the allegations are cited at R52 and R214. Survey date: June 6, 2022 Facility number: 014079 Residential Census: 59 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 8, 2022.	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	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	06/15/2022

	(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 neglected to prevent a cognitively impaired resident, who resided on the secured memory care unit, from leaving the facility without staff supervision. (Resident B) Finding includes: During the initial tour of the secured, memory support unit, on 6/6/22 from 8:15 a.m. to 9:00 a.m. An outdoor courtyard area surrounded by a locked privacy fence approximately six feet tall was observed. The doors to go out to the courtyard area were unlocked. During an interview on 6/6/22 at 8:09 a.m., the Administrator indicated Resident B had exited through a gate door in the courtyard of the secured, memory support unit. The alarm on the gate sounded. The gate was not functioning properly, so it had not locked. Resident B was able to push the gate door open and walk out to the		Resident B was immediately located and returned to Memory Support without injury. Staff were stationed at the door to the courtyard on 5/22/22 until the repair person was available to make the repair. The gate that failed was repaired on 5/23/22. There is a new mag lock on the door from Memory Support into the locked courtyard which was installed on 6/15/22. **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 on Memory Support had the potential to be affected. Staff were stationed at the door to the courtyard on 5/22/22 until the repair person was available to make the repair. The gate that failed was repaired on 5/23/22. There is a new mag lock on the door from Memory Support into the locked courtyard which was installed on 6/15/22. Staff members were educated on the Rhythms Dementia Training on 6/13/22 and 6/14/22. This training	

	parking lot. He was not in sight of the staff. Resident B was found in the parking lot where the employees park. He said he was looking for his car. During an interview on 6/6/22 at 8:20 a.m., QMA 1 (Qualified Medication Aide) indicated she worked with Resident B on the shift before he walked out of the courtyard area and into the parking lot. Resident B had increased behaviors during her shift, that day, because he could not "get out" to check on his car. She also indicated that on approximately five occasions, Resident B had pushed a chair next to the gate in the courtyard area and had attempted to climb the privacy fence to leave. During an interview on 6/6/22 at 8:35 a.m., the DON (Director of Nursing) indicated when Resident B first admitted to the facility, he lived in the assisted living area of the facility. A few days after he admitted, she noticed he had been getting more confused during the afternoon hours, and he indicated that he needed to leave to check on his car. At that time, she spoke to Resident B's daughter, and Resident B was moved to the secured, memory support unit. Resident B exited the courtyard area through the gate door. She was made aware a resident moved chairs in the courtyard area,		provided insight on residents unmet needs and interventions in addition to collaboration with team mates. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**: The gate lock was repaired on 5/23/22. The new mag lock was placed on the door from Memory Support to the courtyard on 6/15/22. The doors/gate are checked weekly by maintenance to ensure they are functioning properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place?** The door and gate will be checked by Maintenance weekly to ensure it is working properly. The documentation will be put into	

	several weeks ago, but was not aware of which resident it was nor why the chairs were moved. During an interview on 6/6/22 at 9:07 a.m., CNA 1 (Certified Nursing Aide) indicated she was familiar with Resident B. He could be aggressive at times. He had thrown his cane. He had also put a chair by the fence and tried to climb the fence several times. When this happened, she reported to the DON. The clinical record for Resident B was reviewed on 6/6/22 at 8:52 a.m. The diagnoses included, but were not limited to, Parkinson's disease, major depressive disorder, and anxiety disorder. A Level of Care Evaluation, dated 3/13/22, indicated Resident B was not always oriented to person, place, and time. He ambulated with a cane and was able to transfer without assistance. The Progress Notes included, but were not limited to: On 5/22/22 at 7:18 p.m., Resident B was having increased behaviors and agitation. Resident B was throwing cane around because he could not get out of the facility. On 5/22/22 at 8:05 p.m., an		TELS. This will be ongoing. The results of the inspections will be brought to the Safety Committee for the next 6 months. The committee will review the report and make recommendations as needed.	

	alarm sounded to outside courtyard. Staff responded and Resident B had exited the gate leading to the parking area. The care team immediately went outdoors and into parking lot where Resident B was walking in the parking area. He said that he was looking for his car so that he could go home. Resident B walked back inside with staff without incident. On 5/22/22 at 9:01 p.m., Resident B left out of the gate and was persistent to leave, so he left when we turned our heads. He was quickly approached in the parking lot. On 5/23/22 at 8:57 a.m., Resident B was expressing concerns and very determined to leave. Left a voicemail for family before end of shift but no return call noted. During an interview on 6/6/22 at 12:10 p.m., QMA 1 indicated yesterday Resident B was outside and she could see another resident was trying to stand on a flower pot to get over the fence. The other resident told her he was trying to leave when she went outside. Resident B told the resident he had an easier way to leave. She intervened before Resident B told the resident how to leave. She did not ask Resident B how he would leave.			

	On 6/6/22 at 1:29 p.m., Resident B was observed to be escorted out into the courtyard by staff. Once Resident B was outside in the courtyard, the staff member walked away. Resident B was outside in the courtyard, unsupervised. On 6/6/22 at 9:17 a.m., the Administrator provided a copy of a facility policy, titled "Elopement and Missing Resident," dated 12/2021, and indicated this was the current policy used by the facility. A review of the policy indicated "the facility has the privilege and responsibility to meet the various needs of residents/clients, including issues related to the potential for a resident to elope, placing the person at risk of harm...elopement is defined as a situation in which a resident with impaired cognition or poor safety awareness or judgement successfully leaves the facility or a secure area undetected or unsupervised by staff." This State tag relates to Complaint IN00380975.			

	Based on observation, interview, and record review, the facility neglected to prevent a cognitively impaired resident, who resided on the secured memory care unit, from leaving the facility without staff supervision. (Resident B) Finding includes: During the initial tour of the secured, memory support unit, on 6/6/22 from 8:15 a.m. to 9:00 a.m. An outdoor courtyard area surrounded by a locked privacy fence approximately six feet tall was observed. The doors to go out to the courtyard area were unlocked. During an interview on 6/6/22 at 8:09 a.m., the Administrator indicated Resident B had exited through a gate door in the courtyard of the secured, memory support unit. The alarm on the gate sounded. The gate was not functioning properly, so it had not locked. Resident B was able to push the gate door open and walk out to the parking lot. He was not in sight of the staff. Resident B was found in the parking lot where the employees park. He said he was looking for his car. During an interview on 6/6/22 at 8:20 a.m., QMA 1 (Qualified Medication Aide) indicated she worked with Resident B on the shift before he walked out of the			

	courtyard area and into the parking lot. Resident B had increased behaviors during her shift, that day, because he could not "get out" to check on his car. She also indicated that on approximately five occasions, Resident B had pushed a chair next to the gate in the courtyard area and had attempted to climb the privacy fence to leave. During an interview on 6/6/22 at 8:35 a.m., the DON (Director of Nursing) indicated when Resident B first admitted to the facility, he lived in the assisted living area of the facility. A few days after he admitted, she noticed he had been getting more confused during the afternoon hours, and he indicated that he needed to leave to check on his car. At that time, she spoke to Resident B's daughter, and Resident B was moved to the secured, memory support unit. Resident B exited the courtyard area through the gate door. She was made aware a resident moved chairs in the courtyard area, several weeks ago, but was not aware of which resident it was nor why the chairs were moved. During an interview on 6/6/22 at 9:07 a.m., CNA 1 (Certified Nursing Aide) indicated she was familiar with Resident B. He could be aggressive at times. He had thrown his cane. He had also put a chair by the fence			

and tried to climb the fence several times. When this happened, she reported to the DON.

The clinical record for Resident B was reviewed on 6/6/22 at 8:52 a.m. The diagnoses included, but were not limited to, Parkinson's disease, major depressive disorder, and anxiety disorder.

A Level of Care Evaluation, dated 3/13/22, indicated Resident B was not always oriented to person, place, and time. He ambulated with a cane and was able to transfer without assistance.

The Progress Notes included, but were not limited to:

On 5/22/22 at 7:18 p.m., Resident B was having increased behaviors and agitation. Resident B was throwing cane around because he could not get out of the facility.

On 5/22/22 at 8:05 p.m., an alarm sounded to outside courtyard. Staff responded and Resident B had exited the gate leading to the parking area. The care team immediately went outdoors and into parking lot where Resident B was walking in the parking area. He said that he was looking for his car so that he could go home. Resident B walked back inside

with staff without incident.

On 5/22/22 at 9:01 p.m., Resident B left out of the gate and was persistent to leave, so he left when we turned our heads. He was quickly approached in the parking lot.

On 5/23/22 at 8:57 a.m., Resident B was expressing concerns and very determined to leave. Left a voicemail for family before end of shift but no return call noted.

During an interview on 6/6/22 at 12:10 p.m., QMA 1 indicated yesterday Resident B was outside and she could see another resident was trying to stand on a flower pot to get over the fence. The other resident told her he was trying to leave when she went outside. Resident B told the resident he had an easier way to leave. She intervened before Resident B told the resident how to leave. She did not ask Resident B how he would leave.

On 6/6/22 at 1:29 p.m., Resident B was observed to be escorted out into the courtyard by staff. Once Resident B was outside in the courtyard, the staff member walked away. Resident B was outside in the courtyard, unsupervised.

On 6/6/22 at 9:17 a.m., the Administrator provided a copy of a facility policy, titled

	"Elopement and Missing Resident," dated 12/2021, and indicated this was the current policy used by the facility. A review of the policy indicated "the facility has the privilege and responsibility to meet the various needs of residents/clients, including issues related to the potential for a resident to elope, placing the person at risk of harm...elopement is defined as a situation in which a resident with impaired cognition or poor safety awareness or judgement successfully leaves the facility or a secure area undetected or unsupervised by staff." This State tag relates to Complaint IN00380975.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview, and record review, the facility failed to evaluate a residents needs after a change in condition for 1 of 3 residents	R 0214	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B's Service Plan was updated to include elopement risk. Interventions were included for behaviors, wandering & elopement risk as appropriate. **How the facility will identify other residents having the**	06/30/2022

reviewed. (Resident B)

Finding includes:

During the initial tour of the secured, memory support unit, on 6/6/22 from 8:15 a.m. to 9:00 a.m. An outdoor courtyard area surrounded by a locked privacy fence approximately six feet tall was observed.

During an interview on 6/6/22 at 8:09 a.m., the Administrator indicated Resident B had exited through a gated door in the courtyard of the secured, memory support unit. The alarm on the gate sounded. The gate was not functioning properly and did not lock. Resident B was able to push the gate door open and walked out to the parking lot. He was not in sight of the staff. Resident B was found in the parking lot where the employees park.

During an interview on 6/6/22 at 8:20 a.m., QMA 1 (Qualified Medication Aide) indicated she worked with Resident B on the shift before he walked out of the courtyard area and into the parking lot. Resident B had increased behaviors during her shift, because he could not "get out" to check on his car. She also indicated that on approximately five occasions, Resident B had pushed a chair next to the gate, in the courtyard area, and tried to climb the

potential to be affected by the same deficient practice and what corrective action will be taken?

All residents on Memory Support have the potential to be affected. All Memory Support residents' service plans were reviewed and updated as needed. The staff were re-educated on Stop and Watch a the monthly all staff meeting. The Stop and Watch communication will be brought to morning meeting to review and determine the need to adjust the service plan.

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

The HWD will monitor the service plans and need for updating. The changes noted on the Stop and Watch communications will be reviewed and the service plans updated upon resident need.

How the corrective action(s) will be monitored to ensure the deficient practice will not

	privacy fence to leave. During an interview on 6/6/22 at 8:35 a.m., the DON (Director of Nursing) indicated when Resident B first admitted to the facility, he lived in the assisted living area of the facility. A few days after he admitted, she noticed he was getting more confused during the afternoon hours, and he indicated that he needed to leave to check on his car. At that time, she spoke to Resident B's daughter, and Resident B was moved to the secured, memory support unit. Resident B exited the courtyard area through the gate door. Resident B's service plan and wander risk should have been updated when we realized he was an elopement risk. The clinical record for Resident B was reviewed on 6/6/22 at 8:52 a.m. The diagnoses included, but were not limited to, Parkinson's disease, major depressive disorder, and anxiety disorder. A Level of Care Evaluation, dated 3/13/22, indicated Resident B was not always oriented to person, place, and time. He ambulated with a cane and was able to transfer without assistance. A Wander Risk Evaluation, dated 3/19/22 at 3:30 p.m., indicated Resident B was		**recur, IE, what quality assurance program will be put into place?** An audit tool was developed to monitor the comprehensive service plans. The HWD/designee will conduct the audit to ensure the service plans are current. The HWD/designee will randomly audit 4 service plans a week for 4 weeks, 2 service plans a week for 8 weeks, then 1 service plan a week for 12 weeks. The results will be submitted monthly to the Quality Assurance Committee for review and recommendations.	

oriented to person, place and time, had not exhibited any behaviors at that time and had no history of wandering.

The clinical record lacked an updated Wander Risk Evaluation.

A Service Plan, dated 3/13/22 and current through 6/11/22, lacked any intervention for behaviors, wandering, or elopement risk.

On 6/6/22 at 9:17 a.m. The Administrator provided a copy of a facility policy, titled "Elopement and Missing Resident," dated 12/21, and indicated this was the current policy used by the facility. A review of the policy indicated "the elopement risk assessment is updated, as needed, to address any changes in the resident's/client's condition, including behavioral manifestations that indicate an increased potential for elopement."

This State tag relates to Complaint IN00380975.

Based on observation, interview, and record review, the facility failed to evaluate a residents needs after a change in condition for 1 of 3 residents reviewed. (Resident B)

Finding includes:

During the initial tour of the secured, memory support unit, on 6/6/22 from 8:15 a.m. to 9:00 a.m. An outdoor courtyard area surrounded by a locked privacy fence approximately six feet tall was observed.

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A Wander Risk Evaluation, dated 3/19/22 at 3:30 p.m., indicated Resident B was oriented to person, place and time, had not exhibited any behaviors at that time and had no history of wandering.

The clinical record lacked an updated Wander Risk Evaluation.

A Service Plan, dated 3/13/22 and current through 6/11/22, lacked any intervention for behaviors, wandering, or elopement risk.

On 6/6/22 at 9:17 a.m. The Administrator provided a copy of a facility policy, titled "Elopement and Missing Resident," dated 12/21, and indicated this was the current policy used by the facility. A review of the policy indicated "the elopement risk assessment is updated, as needed, to address any changes in the resident's/client's condition, including behavioral manifestations that indicate an increased potential for elopement."

This State tag relates to Complaint IN00380975.

SIGNATURE		