STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF DYER	1763 CALUMET AVENUE, DYER, , 46311

(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 IN00464872. Intake IN00464872 - State deficiency related to the allegations is cited at R0052. Survey date: 9/25/25 Facility number: 014415 Residential Census: 74 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/29/25.	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: (1) sexual abuse; (2) physical abuse;	R 0052	**R052** **Resident Rights:** **What corrective action(s) will be**	10/11/2025

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on record review and interview, the facility failed to supervise and prevent a memory care resident with a history of exiting the building from exiting again for 1 of 3 residents reviewed for exit-seeking. (Resident B)

Finding includes:

The record for Resident B was reviewed on 9/25/25 at 10:40 a.m. Diagnoses included, but were not limited to, diabetes, dementia, and Alzheimer's.

An Indiana Department of Health (IDOH) facility reported incident, dated 9/6/25, indicated Resident B eloped from the memory care (MC) unit as a visitor was entering into the unit. The resident exited out of the east stairwell doors onto the sidewalk. The family member notified staff immediately. The resident was located and returned back to MC.

An Elopement Care Plan, dated 9/6/25, indicated, "Provide supervision and redirection to avoid and prevent elopement. Provide checks throughout the

accomplished for those residents found to have been affected
by the deficient practice.

Resident B's care plan and elopement risk assessment have been updated. Medications have been reviewed and revised. Medic Alert bracelet Paperwork has been provided to the POA for review and consent.

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 memory care residents have the potential to be affected by the same deficient practice.

	day / night and document whereabouts...". A Change in Condition Assessment, dated 9/8/25, indicated the resident was not cognitively intact for daily decision making and was a high risk for elopement. An IDOH facility reported incident, dated 9/16/25, indicated Resident B exited the memory care unit around 8:00 a.m., unescorted by staff or family member. A staff member observed the resident outside of the building at 8:15 a.m. walking down the side walk in front of the building. The staff member escorted the resident back into the facility. No injuries were noted. The facility incident investigation included written statements from the staff on duty at the time of the incident on 9/16/25. The statement by CNA 1 indicated when she exited the memory care unit, the resident walked out behind her. She did not know the door had not closed.		**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** All staff in-service on abuse, elopement, wandering, and exit-seeking behaviors. The memory care door code has been changed. . **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.** -Elopement drills monthly for the next 3 months and quarterly after	

	The statement by CNA 2 indicated she had checked on the resident in her room, then went into another resident's room to get them up for breakfast. When she returned to the resident's room, she was gone. The statement by CNA 3 indicated she was in another resident's room at the time the resident eloped. She did not see the doors to the memory care unit open before she went to assist the other resident. During an interview on 9/25/25 at 2:05 p.m. the administrator indicated the staff who were on duty in the memory care during the 9/16/25 incident were written up for unsatisfactory job performance for not keeping residents in sight at all times. They should have been supervising the residents to prevent elopement. A policy titled, "Safety Checks", received as current from the Administrator on 9/25/25 at 3:41 p.m., indicated, " ... When Safety Checks have been identified as necessary, a systematic approach for Resident monitoring will be provided with routine safety checks and documented on the Resident's Individualized Service Plan ... A Resident on Safety Checks will be physically visited to account for		-Elopement risk assessment will be conducted on all residents upon admission, every 6 months and change of condition. **By what date the systemic changes will be completed.** 10/11/25	

whereabouts...".

This citation relates to Intake IN00464872.

Based on record review and interview, the facility failed to supervise and prevent a memory care resident with a history of exiting the building from exiting again for 1 of 3 residents reviewed for exit-seeking. (Resident B)

Finding includes:

The record for Resident B was reviewed on 9/25/25 at 10:40 a.m. Diagnoses included, but were not limited to, diabetes, dementia, and Alzheimer's.

An Indiana Department of Health (IDOH) facility reported incident, dated 9/6/25, indicated Resident B eloped from the memory care (MC) unit as a visitor was entering into the unit. The resident exited out of the east stairwell doors onto the sidewalk. The family member notified staff immediately. The resident was located and returned back to MC.

An Elopement Care Plan, dated 9/6/25, indicated, "Provide supervision and redirection to avoid and prevent elopement. Provide checks throughout the day / night and document whereabouts...".

A Change in Condition

Assessment, dated 9/8/25, indicated the resident was not cognitively intact for daily decision making and was a high risk for elopement.

An IDOH facility reported incident, dated 9/16/25, indicated Resident B exited the memory care unit around 8:00 a.m., unescorted by staff or family member. A staff member observed the resident outside of the building at 8:15 a.m. walking down the side walk in front of the building. The staff member escorted the resident back into the facility. No injuries were noted.

The facility incident investigation included written statements from the staff on duty at the time of the incident on 9/16/25.

The statement by CNA 1 indicated when she exited the memory care unit, the resident walked out behind her. She did not know the door had not closed.

The statement by CNA 2 indicated she had checked on the resident in her room, then went into another resident's room to get them up for breakfast. When she returned to the resident's room, she was gone.

The statement by CNA 3 indicated she was in another resident's room at the time the

resident eloped. She did not see the doors to the memory care unit open before she went to assist the other resident.

During an interview on 9/25/25 at 2:05 p.m. the administrator indicated the staff who were on duty in the memory care during the 9/16/25 incident were written up for unsatisfactory job performance for not keeping residents in sight at all times. They should have been supervising the residents to prevent elopement.

A policy titled, "Safety Checks", received as current from the Administrator on 9/25/25 at 3:41 p.m., indicated, " ... When Safety Checks have been identified as necessary, a systematic approach for Resident monitoring will be provided with routine safety checks and documented on the Resident's Individualized Service Plan ... A Resident on Safety Checks will be physically visited to account for whereabouts...".

This citation relates to Intake IN00464872.

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 SIGNATUREJaqueisha Johnson	TITLEDON	(X6) DATE10/07/2025