STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE OF DANVILLE	200 S ARBOR LANE, DANVILLE, , 46122

(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 Intakes 466219, 466313, and 467196. Intake 466219- State deficiencies related to the allegations are cited at R52. Intake 466313 - No deficiencies related to the allegations are cited. Intake 467196 - No deficiencies related to the allegations are cited. Survey date: March 25, 26, and 27, 2026 Facility number: 014518 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 13, 2026.	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; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect when a confused resident residing in a secured memory care (MC) unit exited the facility without staff knowledge for 1 of 3 residents reviewed for accidents (Resident D). Findings include: A Facility Reported Incident (FRI), dated 3/2/26 at 8:45 p.m., indicated the fire alarm system was activated resulting in memory care unit doors being unsecured. Resident D went out an exit door into the main parking lot of the community. Nursing was alerted that there was a person in the parking lot	R 0052		04/16/2026

that had fallen, and at that time identified that it was Resident D from their memory care unit.

A fall incident report, dated 3/2/26 at 9:25 p.m., indicated Licensed Practical Nurse (LPN) 9 received a call from a visitor stating that a resident was lying on the ground in the parking lot. LPN 9 went to the scene and found Resident D lying face down on the ground of the front parking lot. The resident was alert to self and surroundings but couldn't state how he exited the building and got on the ground of the parking lot. Resident D was assessed and found to have a skin tear on his left elbow and a dark bruise on the right forearm. The resident was sent via ambulance to a local hospital for evaluation and treatment.

A local hospital report, dated 3/2/26, indicated Resident D was transported to the emergency room (ER) by emergency medical services (EMS) after a fall at the facility where he lived in a memory care unit. The resident had a skin tear on the left elbow and the bleeding was controlled with direct pressure. Given that the resident's history was secondary to dementia, a head computed tomography (CT scan), and x-ray of the left elbow were performed.

A Grievance Report, dated 3/9/26, indicated Resident D's responsible party had "neglect and safety concerns." Resident D had walked outside by himself during a fire alarm, he fell, and a person in the parking lot had found him and called 911. The resident was taken to the emergency room (ER) with no paperwork, health cards, or identification. Resident D was returned to the facility by his son around 12:30 a.m. Staff did not check on the resident throughout the night. The responsible party indicated there was video footage as proof of his concerns.

On 3/25/26 at 1:58 p.m., Resident D was observed sitting quietly in his room on the secured memory care (MC) unit, the door open and the resident visible from the hallway. A resident biography (history) hung outside the doorway with a warning that there was a video camera in use in the room.

On 3/26/26 at 11:22 a.m., Resident D was observed in the MC dining room sitting quietly at the counter with a peer looking around. The resident smiled when spoken to but did not verbalize a response when asked if he had recently fallen.

On 3/26/26 at 11:38 a.m., a red exit sign hung from the ceiling outside of Resident D's doorway

and an exit door to the front parking lot was observed 2 doors down from his room.

On 3/27/26 at 10:29 a.m., Resident D's door to the hallway was closed. The resident was observed standing in front of the counter in the bathroom scrolling on his phone. The resident responded with a smile when spoken to and verbally responded with sentences not related to the greeting or comment of checking to make sure he was okay.

On 3/27/26 at 10:38 a.m., Resident D was observed ambulating independently without his walker to the dining area and prompted to sit in the circle of chairs for exercises among his peers.

Resident D's clinical record was reviewed on 3/26/26 at 2:00 p.m. Diagnoses on Resident D's profile included dementia with behavioral disturbance and a history of falling.

A service plan, dated 11/19/25, indicated Resident D was at risk for elopement and the goal was the resident would not leave the community unattended. Interventions included observing the resident's location in the community.

A service plan, dated 11/19/25, indicated Resident D was at risk

for falls, and the goal was to encourage the resident to call for assistance when needed. Interventions included the resident would back up to a chair prior to sitting and feel the chair on the back of his legs prior to sitting down.

A Level of Care Assessment, dated 1/7/26, indicated the resident was in a memory care unit. He ambulated to the dining room and ate his meals unassisted. The resident was independent with communication, transfers, ambulation with a walker, toileting, grooming and oral hygiene, and dressing and undressing. The resident was not always oriented and required supervision to make safe judgements and function appropriately in social situations. The resident was at risk for elopement, and staff was to observe the resident's location in the community, and the resident was not to leave the community unattended.

A progress note, dated 2/24/26 at 4:07 p.m., indicated Resident D was "very exit seeking" wanting to go to the doctor. The resident had been calling his family stating he needed his oil changed.

A progress note, dated 3/3/26 at 12:47 a.m., indicated Resident D returned from a local hospital

accompanied by his son at 12:30 a.m.

A progress note, dated 3/3/26 at 7:40 a.m., indicated at 9:25 p.m., LPN 9 documented he had received a call from a visitor stating that a resident was lying on the ground in the parking lot. LPN 9 went to the scene and found Resident D lying face down on the ground of the front parking lot. The resident was sent via ambulance to a local hospital for evaluation and treatment.

A fall follow-up progress note, dated 3/6/26 at 10:56 a.m., indicated staff was to do rounds every 2 hours. Staff was to always be present and aware in memory care especially during fire alarms.

A facility website description of the memory care unit services indicated, "Memory care is a specialized type of senior living designed to support individuals with Alzheimer's and other forms of dementia. Memory care facilities provide a secure environment with 24/7 support from trained professionals who understand the unique needs of individuals with memory loss ...Our communities are designed to ensure safety - offering secure entrances, emergency response systems, and staff trained to handle the challenges of memory-related

conditions ...Memory care is designed specifically for individuals with dementia, offering a higher level of security, cognitive support, and structured care ...Memory care offers a higher staff-to-resident ratio, security measures with features such as secured doors and alarmed exits to prevent wandering."

During an interview on 3/25/26 at 2:05 p.m., LPN 4 indicated Resident D had a security camera in his room that was placed by a family member. There was a sign posted outside his doorway to alert others regarding the presence of the camera.

During an interview on 3/26/26 at 9:50 a.m., Resident D's responsible party indicated he had filed a written grievance on 3/9/26 after the resident had gotten out during a fire alarm and the staff did not know he was gone. On 3/2/26 Resident D had walked out of the facility after dark dressed only in pajama pants, a short sleeved t-shirt, and socks. He was not wearing shoes or a coat, and did not have his walker. The representative indicated, if the resident had not fallen and been found by a visitor, he could have walked away into the surrounding corn fields or wandered off down the country

road. Resident D had been sent to the ER without paperwork, and when the resident's representative got to the ER, he was told by staff they were waiting to treat the resident as they did not have copies of his orders or allergies. The resident representative indicated, Resident D was in a secured MC unit and the expectation was that he would be monitored and safe from wandering off.

During an interview on 3/26/26 at 11:35 a.m., LPN 4 and Qualified Medication Aide (QMA) 6 both indicated they had not been present on 3/2/26 when Resident D had gone outside on his own, and did not know which exit door he had gone out of.

During an interview on 3/26/26 at 11:40 a.m. QMA 6 and QMA 7 indicated they had recently been educated on the fire alarm process. QMA 6 indicated, if the fire alarm sounded all of the MC unit exit doors would unlock, and staff were all supposed to monitor each exit until the fire doors were relocked.

During an interview on 3/27/26 at 10:32 a.m., QMA 10 indicated, staff were supposed to do rounds and check on the residents in the MC unit every 2 hours.

During an interview on 3/27/26

at 12:55 p.m., the Executive Director (ED) indicated, on 3/2/26 around 8:45 p.m., the fire alarm was activated when an Assisted Living (AL) resident on the 3rd floor had burnt popcorn in the microwave, and the MC doors automatically unlocked. The evening nurse working on the MC unit was supposed to check the fire panel in the service corridor or at the front of the facility to determine the location of the potential fire, and the MC staff were to stay on MC with the residents until given further instructions. Review of video footage on the MC unit showed a staff member doing a "head count", and after passing by Resident D who was walking up and down the hallway outside of his room, the staff member went into 2 other resident rooms at the end of the hallway to provide care. Resident D was observed leaving the building through an exit door near his room. The ED indicated staff did not know the resident had exited the facility until they received a call from a visitor reporting the resident was found on the ground in the parking lot. LPN 9 had been responsible for assuring residents on the MC unit were counted and present.

A Fire Drill Record, dated 2/24/26, indicated staff that were working on the evening of

	3/2/26 when Resident D exited the facility without staff knowledge, had signed as having participated in the fire drill. A Fire Drill Response protocol, undated, indicated, "All assigned to Memory Care are to monitor door/exits and residents, head count when all clear..." This State citation relates to Intake 466219.			

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