STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE, SOUTH BEND, , 46614

(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 IN00463291. Complaint IN00463291 - Deficiencies related to the allegations are cited at R0052. Survey date: July 17 and 18, 2025. Facility number: 014602 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 7/22/2025	R 0000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. St. Paul's respectfully requests the Plan of Correction and supporting documentation be considered by Desktop review. We declare the date of compliance is 7/17/25	
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 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	07/18/2025

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview, observation and record review, the facility failed to ensure the safety of 1 of 3 residents reviewed for elopement. (Resident B) Finding includes: A review of a self-reported incident was completed on 7/17/2025 at 1:10 P.M. The incident report indicated Resident B had eloped on 7/9/2025 from the secured Memory Care unit of the facility. Resident B's record review was completed on 7/17/2025 at 1:15 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, hypertension, anxiety and depression. Resident B's Admission Service Plan, dated 9/20/2024, indicated the resident required a Wanderguard (a system that utilizes wearable bracelets, door sensors, and a technology platform to monitor resident movement and trigger alerts when a resident approaches a restricted area) due to pacing		Answer: The residents wander guard was checked for placement and functionality, the resident was placed on 15-minute checks immediately and then placed on 1 on 1 supervision. The resident remains on 1 on 1 supervision between the hours of 6 p.m. – 11 p.m. Great Lakes Behavioral Health assessed the resident and continues to provide support. The colleague assigned to the resident at the time of elopement was suspended immediately pending investigation and was later terminated. 2 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? Answer: All residents who reside in the Memory Care unit have the potential to be affected. A head count was immediately performed to ensure that all residents on the Memory Care unit were accounted for. The wander guard system was checked to ensure function. All	

	and exit-seeking. An Elopement Assessment for Resident B, completed on 3/13/2025, indicated a score of 8 (a score of 3 or more indicated the resident should reside on the Memory Care unit and required a Wanderguard). During an interview, on 7/17/2025 at 1:15 P.M., the Director of Nursing (DON) indicated on 7/10/2025 at 1:00 A.M., she had been notified by the charge nurse that the local police department had been at the facility and had notified the charge nurse that Resident B had been found at a gas station and was taken to a local hospital. The police officer reported the resident had been found with scratches on her knees and a laceration above her right eye. The Emergency Department notes, dated 7/10/2025 at 12:39 A.M., indicated Resident B was found wandering at a gas station with a laceration to her right forehead, bruise to her shoulder and an abrasion to her right knee. The resident required seven sutures to repair the laceration above her right eye. Resident B's record indicated although family had concerns for the resident's safety, due to the resident's history of dementia, the family felt the Memory Care unit at the		residents who wear wander guards were checked for placement and functionality. All residents who reside on the Memory Care Unit were reviewed to identify any exit seeking or wandering behavior. Their Life Histories were reviewed to ensure that appropriate interventions are in place and reflected on their service plans. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Answer: The wander guard service provider thoroughly assessed the system to ensure that it is functioning properly. Alarm “screamers” (loud alarms) were added to the patio door, patio gate and egress doors. Missing pagers were immediately replaced. Elopement drills were completed on all shifts within 24 hours of the incident. All licensed and certified clinical personnel (Nurses, QMA’s & CNA’s) were provided with education regarding elopement, pagers and rounding with 100%	

current facility would be best for their mother at the current time. Resident B was discharged back to the facility at 6:25 A.M. on 7/10/2025.

During an interview, on 7/17/2025 at 1:30 P.M., the DON indicated on 7/9/2025 at 8:36 P.M., the alarm to the patio door of the Memory Care unit had sounded. Employee 6 had shut the door and had entered the code to turn the alarm off. The DON indicated Employee 6 had not checked the area, the patio or completed a head count to ensure no residents had gone out of the door unattended. At 8:38 P.M., the alarm to the patio gate sounded. However, the patio gate alarm could not be heard inside the building. The alarm was normally sent to the pager system for the Memory Care unit staff, but the unit's pagers were all missing. The DON indicated the pagers had been missing for three days but no staff had reported the missing pagers to her or the Administrator. Next, the patio gate alarm sent a visible message to the call light computer screen, located at the nursing station. The patio gate alarm message had appeared in red on this screen, however, unit staff failed to notice the message. The DON indicated the facility staff had also failed to complete rounds every 2 hours as required by the facility

completion achieved by 7/17/25. Pager sign-in/sign-out and rounding sheets will be audited by the DON or designee daily for 8 weeks, then twice weekly thereafter. The Maintenance Department will check the wander guard system twice weekly for 8 weeks and then weekly thereafter to ensure proper functioning. All new hires of licensed/certified clinical staff (Nurses, QMA's & CNA's) will receive additional education about policies and procedures related to elopement, pagers, rounding and door alarms.

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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?

Answer: The pager sign-in/sign-out document and rounding sheets will be audited daily for 8 weeks, then twice weekly thereafter. Maintenance will check the wander guard system twice weekly for 8 weeks then weekly thereafter. Elopement drills have been increased from quarterly to

	policy. The facility staff were unaware Resident B had eloped until the police had notified the facility. The DON indicated upon hire all staff working on the Memory Care unit on the evening and night of 7/9/2025 had been educated on elopement policies, the use of the Wanderguard system, door alarms and resident rounding. A record review of Employee 4 was completed on 7/18/2025 at 11:00 A.M. The record indicated that Employee 4 had completed training for resident rounding, alarms/emergency code systems and paging systems on 10/7/2022. A record review for Employee 5 was completed on 7/18/2025 at 11:05 A.M. The record indicated that Employee 5 had completed training for resident rounding, alarms/emergency code systems and paging systems on 1/13/1992. A record review of Employee 6 was completed on 7/18/2025 at 11:10 A.M. The record indicated that Employee 5 had completed training for resident rounding, alarms/emergency code systems and paging systems on 3/28/2014. During an interview, on 7/17/2025 at 2:00 P.M., a family member for Resident B indicated she was glad the		monthly for 6 months. If the process has been deemed in compliance by QAPI, quarterly elopement drills may resume.	

resident had an old address book with her when the police had found her, otherwise no one would have known how to get her back where she belonged or who the resident was. The family member indicated she felt Resident B was not safe living at the current facility.

A review of the facility's investigation related to the elopement, dated 7/10/2025, indicated Employee 5 indicated when she had arrived for her shift on 7/9/2025, she had received report, counted narcotics and had assisted another resident. Employee 5 indicated when she was delivering clothes and ice water at 11:00 P.M., Resident B's room was dark and she had assumed the resident was sleeping. Employee 5 indicated she never heard any of the alarms. Employee 6 indicated she had worked the evening shift and had completed a resident rounding sheet on 7/9/2025. Employee 6 had charted Resident B as in bed at 10 P.M. but had not entered the resident's room. Employee 6 indicated she had also reset the patio door code at 8:36 P.M. and had seen Resident B walking away from the door. She indicated she had not heard the patio gate alarm. Employee 4 indicated ,on 7/9/2025, she had worked the evening shift but had not carried

a pager because the CNAs usually carried the pagers so she just looked at the computer for any alarms and call lights. Employee 4 had initialed a rounding sheet indicating Resident B was present in the Memory Care unit at 10 P.M.

A review of the patio door alarm record for the Memory Care unit indicated the patio door alarm had sounded, on 7/9/2025 at 8:36 P.M. and was not turned off for 4 minutes and 4 seconds.

A review of the patio gate alarm record for the Memory Care unit indicated the patio gate alarm had sounded, on 7/9/2025 at 8:38 P.M. and was not turned off for 10 hours.

An Evening Shift Rounds paper, dated 7/9/2025, indicated Resident B had been marked as being on the Memory Care unit at 10 P.M. on 7/9/2025.

On 7/18/2025 at 11:15 A.M., the DON provided a policy titled, "Routine Resident Checks," dated 6/2019 and indicated the policy was the one currently used by the facility. The policy indicated " ...Routine resident checks shall be made to assure that the resident's safety ...To ensure that the safety and well-being of our residents-elders, a resident check will be made at least every 2 hours throughout each

24-hour shift by nursing service personnel ..."

This citation relates to Complaint IN00463291

Based on interview, observation and record review, the facility failed to ensure the safety of 1 of 3 residents reviewed for elopement. (Resident B)

Finding includes:

A review of a self-reported incident was completed on 7/17/2025 at 1:10 P.M. The incident report indicated Resident B had eloped on 7/9/2025 from the secured Memory Care unit of the facility.

Resident B's record review was completed on 7/17/2025 at 1:15 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, hypertension, anxiety and depression.

Resident B's Admission Service Plan, dated 9/20/2024, indicated the resident required a Wanderguard (a system that utilizes wearable bracelets, door sensors, and a technology platform to monitor resident movement and trigger alerts when a resident approaches a restricted area) due to pacing and exit-seeking.

An Elopement Assessment for Resident B, completed on 3/13/2025, indicated a score of

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The Emergency Department notes, dated 7/10/2025 at 12:39 A.M., indicated Resident B was found wandering at a gas station with a laceration to her right forehead, bruise to her shoulder and an abrasion to her right knee. The resident required seven sutures to repair the laceration above her right eye. Resident B's record indicated although family had concerns for the resident's safety, due to the resident's history of dementia, the family felt the Memory Care unit at the current facility would be best for their mother at the current time. Resident B was discharged back to the facility at 6:25 A.M. on 7/10/2025.

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DON indicated the pagers had been missing for three days but no staff had reported the missing pagers to her or the Administrator. Next, the patio gate alarm sent a visible message to the call light computer screen, located at the nursing station. The patio gate alarm message had appeared in red on this screen, however, unit staff failed to notice the message. The DON indicated the facility staff had also failed to complete rounds every 2 hours as required by the facility policy. The facility staff were unaware Resident B had eloped until the police had notified the facility. The DON indicated upon hire all staff working on the Memory Care unit on the evening and night of 7/9/2025 had been educated on elopement policies, the use of the Wanderguard system, door alarms and resident rounding.

A record review of Employee 4 was completed on 7/18/2025 at 11:00 A.M. The record indicated that Employee 4 had completed training for resident rounding, alarms/emergency code systems and paging systems on 10/7/2022.

A record review for Employee 5 was completed on 7/18/2025 at 11:05 A.M. The record indicated that Employee 5 had completed training for resident rounding, alarms/emergency code

systems and paging systems on 1/13/1992.

A record review of Employee 6 was completed on 7/18/2025 at 11:10 A.M. The record indicated that Employee 5 had completed training for resident rounding, alarms/emergency code systems and paging systems on 3/28/2014.

During an interview, on 7/17/2025 at 2:00 P.M., a family member for Resident B indicated she was glad the resident had an old address book with her when the police had found her, otherwise no one would have known how to get her back where she belonged or who the resident was. The family member indicated she felt Resident B was not safe living at the current facility.

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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