STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF COLUMBUS	4300 WEST GOELLER BLVD, COLUMBUS, , 47201

(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 IN00368997. Complaint IN00368997-Substantiated. State deficiency related to the allegations is cited at R0052. Survey date: December 29, 2021 Facility number: 015179 Residential Census: 46 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 3, 2022.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **In response to R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights** **Deficiency:** **(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.** **What corrective actions will be accomplished for those residents found to have been affected by the finding:** Resident B was placed on a 1:1 supervision and will continue to have a 1:1 caregiver 24 hours a day while residing at our facility.	

			-Completed 1/10/22 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place: No resident was adversely affected though the potential for adverse outcome did exist. The Wellness Director did a full audit on all medical charts to screen for other residents that are a potential elopement risk. Our Interdisciplinary Team will review those residents monthly during our QA meeting and add interventions as needed. -Completed 1/12/22 and ongoing monthly The Director of Wellness along with the Memory Care Director will screen all new admission for elopement risk. Documentation of screening will be signed off on by the Director of Wellness and the Executive Director. The	

			documentation of screening will be kept in the resident's medical chart. -Completed 1/13/22 and ongoing monthly **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** **How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** The Director of Wellness along with the Memory Care Director will screen all new admission for elopement risk. Documentation of screening will be signed off on by the Director of Wellness and the Executive Director. The documentation of screening will be kept in the resident's medical chart. -Completed 1/13/22 and ongoing monthly The Executive Director had our	

			nurse call vendor change out the lock on the main entrance to memory care for a Mag Lock with a DSM switch for anti-tailgating. -Completed 1/10/22 The Executive Director conducted a mandatory Inservice for employees to review elopement policy and procedures. The Executive Director will retain documentation of the Inservice. -Completed 1/13/22 Elopement Policy and Procedures will be reviewed during general orientation for each new employee. Documentation of this will be kept in each employee file. -Completed 1/13/22 and ongoing **What date the**	

			systemic changes will be completed: 1/13/22 and ongoing	
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 provide a safe environment for 3 of 4 residents reviewed for elopement resulting in a resident being found in a ditch by the road. (Residents B, C, and D) Findings include: 1. The clinical record for Resident B was reviewed on 12/29/21 at 10:01 am. The resident's diagnoses included, but were not limited to, diabetes,	R 0052	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **In response to R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights** **Deficiency:** **(V) Residents have the right to be free from:**	01/13/2022

hyperlipidemia, and a-fib. The resident was very confused and resided in a locked dementia unit.

A Progress Note, dated 12/13/21 at 7:15 a.m., indicated Resident B was found by staff, off of the unit. Reviewed video footage which found resident going out the door behind a family member, who had put the code in. Resident elopement time was 5:43 p.m. By 5:45 p.m. staff began their search for the resident. Resident B was found in grassy area in front of building. Resident was assessed and escorted back into the building.

A Progress Note, dated 12/10/21 at 4:29 p.m., indicated Resident B had been exit seeking and hard to redirect.

A Progress Note dated 12/10/21 at 12:25 p.m., indicated Resident B had been exit seeking for a long period of time. He had figured out how to open the windows, and to pull them out completely. Items belonging to the resident were found outside a window and bought back in.

A Progress Note, dated 12/9/21 at 3:02 p.m.. indicated Resident B was agitated and exit seeking.

During an observation, interview, and record review on 12/29/21 at 10:28 a.m., the

(1) Sexual Abuse;

(2) Physical Abuse;

(3) Mental Abuse;

(4) Corporal Punishment;

(5) Neglect; and

(6) Involuntary Seclusion.

What corrective actions will be accomplished for those residents found to have been affected by the finding:

Resident B was placed on a 1:1 supervision and will continue to have a 1:1 caregiver 24 hours a day while residing at our facility.

	Administrator provided Incident Reports 9, 10, and 11. The Administrator indicated she had reviewed video from Incident 11 that occurred on 12/13/21 5:43 p.m. The video showed Resident B standing just around the corner, when a family member exited the Memory Care unit door. The video showed him run to get out the door before it closed, he ran down the main hall, out the front door, down the hill, and was close to the road when staff located him. One staff member got in a car and drove down the hill and got him. She walked to the front entry door and pointed down the hill toward the main road by the facility. Observed a long curvy drive, with a side walk on the left, at the main road the sidewalk turned left, and approximately one tenth of a mile, ended with in a grassy area. During an interview on 12/29/21 at 11:20 a.m., the Culinary Director indicated he was working on 12/13/21 and around 6:00 p.m. he was notified a resident was missing. He went out the back door and walked left toward the Villas. He was walking with the Wellness Director, from the right side of the building toward the front door, when he looked to his left and saw a car down on the road with its flashers on, so they went down to investigate. There was		-Completed 1/10/22 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place: No resident was adversely affected though the potential for adverse outcome did exist. The Wellness Director did a full audit on all medical charts to screen for other residents that are a potential elopement risk. Our Interdisciplinary Team will review those residents monthly during our QA meeting and add interventions as needed. -Completed 1/12/22 and ongoing monthly The Director of Wellness along with the Memory Care Director will screen all new admission for elopement risk. Documentation of screening will be signed off on by the Director of Wellness and the Executive Director. The documentation of screening will	

	someone passing by and said they saw the resident fall, so they stopped, put on their flashers, and were calling 911. The Culinary Director indicated Resident B was observed with his feet in the ditch and his body on the grassy part. It was just past where the sidewalk ended. Resident B responded to his name, indicated he was ok, but was "just cold." The temperature was in the high 40's or low 50's Fahrenheit, but it was after it rained so the ground was wet, soggy, and muddy. A nurse brought a car down and got him and returned him to the building. During an interview on 12/29/21 at 12:18 p.m., LPN (licensed practical nurse) 2 indicated on 12/13/21, she had just come on shift and was getting report on the Assisted Living side, when she got the message on the radio, that Resident B had got out of the building. By the time she got down to the main floor, the Wellness Director had called on the radio, and asked her to get her car and come get the resident. She indicated at that time of night, around 6:00 p.m., it was really dark and the road was super busy. She indicated some people had stopped on the road and had their flashers on. She took her truck, went down, got Resident B into her truck, and returned him to the building.		be kept in the resident's medical chart. -Completed 1/13/22 and ongoing monthly **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** **How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** The Director of Wellness along with the Memory Care Director will screen all new admission for elopement risk. Documentation of screening will be signed off on by the Director of Wellness and the Executive Director. The documentation of screening will be kept in the resident's medical chart. -Completed 1/13/22 and ongoing monthly The Executive Director had our nurse call vendor change out	

During an interview on 1/29/21 at 12:24 p.m., LPN 3 indicated she was working on the Memory Care unit on 12/13/21. She had served dinner around 5:30 p.m. Around 5:45 p.m., she was in the kitchen area of the dining room cleaning up, when she saw Resident B talking to a CNA (certified nurse aide). LPN 3 indicated none of the staff had heard a door alarm, but because the resident could not be easily located, staff did a room to room search. About that time, the Wellness Director called on the radio and said they had found him down by the main road.

During an observation on 12/29/21 at 12:35 p.m., the road in front of the facility was a four lane road with a center island, leading into a highly populated area, with several apartment communities, housing editions, several large churches, and a few businesses.

2. The clinical record for Resident C was reviewed on 12/29/21 at 11:21 a.m. The resident's diagnoses included, but were not limited to, depression, diabetes, dementia, and thyroid disease. The resident resided in a locked dementia unit.

A Progress Noted, dated 11/6/21 at 8:30 p.m., indicated Resident C had held the

the lock on the main entrance to memory care for a Mag Lock with a DSM switch for anti-tailgating.

-Completed 1/10/22

The Executive Director conducted a mandatory Inservice for employees to review elopement policy and procedures. The Executive Director will retain documentation of the Inservice.

-Completed 1/13/22

Elopement Policy and Procedures will be reviewed during general orientation for each new employee. Documentation of this will be kept in each employee file.

-Completed 1/13/22 and ongoing

What date the systemic changes will be

	emergency handle down long enough, to open the exit door to stairway 5. She walked out of the building and straight across the drive to a Villa home. The Villa resident's caregiver took Resident C into the apartment and notified the main building. Resident C was returned to her apartment. A Progress Noted, dated 8/4/21 9:19 p.m., indicated Resident C was trying to find the door so she could go home. Resident C held down the emergency handle on the main entrance door, of the Memory Care Unit, exited, and walked three feet outside of the door, into the main building hallway. The nurse was able to get the resident back on the unit. A Progress Noted, dated 7/19/21 at 4:29 p.m., indicated Resident C was seen holding down on the emergency handle of the door, long enough until it opened, and proceeded out of it. Staff ran after her, following her out into the parking lot. A Progress Noted, dated 7/3/21 at 4:20 a.m., indicated as staff were taking Resident C to bed, it was noticed the screen from the window was torn out. The staff looked closer and saw the window was open. The Wellness Director was alerted and found other rooms on the Memory Care unit with open		**completed:** 1/13/22 and ongoing	

windows.

A Progress Noted, dated 6/29/21 at 11:43 p.m., indicated Resident C was pacing the halls looking for an exit and pushed on the exit door a few times.

During an observation and interview on 12/29/21 at 10:46 a.m., the Administrator indicated Resident C had exited to the outside of the building, using the Stair 5 exit. The resident was going out toward the parking area, when a private caregiver in the villa across the street saw her, and at the same time, staff had heard the door alarm and caught up with her on the sidewalk just outside the door, and returned her to the building. Observed the sidewalk outside to lead to a parking area, with a street directly behind it, with another parking area, and the Villa Apartments across the street.

During an interview on 12/29/21 at 12:18 p.m., LPN 2 indicated when Resident C got out of the building, she had exited through the Stair 5 exit door, and went across the street to the Villas, knocked on a door, and was let in. The caregiver for the Villa resident called to let the building know she had the resident, and wanted someone to come get her. LPN 2 indicated she went to the Memory Care unit. The Wellness Director told LPN 2,

he had not heard the door alarm, because the room he was in had the TV up really loud. She stayed with the Memory Care residents while the Wellness Director went to get Resident C. The door alarms for the Memory Care unit are not usually heard in the main building. If you were on the main floor, near the front door, you might hear them.

3. The clinical record for Resident D was reviewed on 12/29/21 at 11:55 am. The resident's diagnoses included, but were not limited to, dementia, diabetes, and a-fib. The resident resided in a locked dementia unit.

A Progress Noted, dated 12/28/21 at 11:15 p.m., indicated Resident D attempted to exit the unit two times during the shift, between 6:00 p.m. and 8:00 p.m.

A Progress Noted, dated 12/28/21 at 12:50 p.m., indicated staff followed Resident D to the Memory Care door and watched as he tried to put in the code for the keypad, to allow the door to open.

A Progress Noted, dated 12/28/21 at 9:45 a.m., indicated Resident D had one episode of exit seeking that morning, right after breakfast.

A Progress Noted, dated

12/28/21 at 5:22 a.m., indicated two hour safety checks were done on Resident D, because he was trying to get out of the facility. The resident got up twice on night shift and both times tried to open the exit door. Staff were trying to redirect the resident while at the door, when the resident stated, "how do you get out of here? I know you have to put some numbers in."

A Progress Noted, dated 12/28/21 at 12:54 a.m., indicated Resident D ambulated on the unit from his room at approximately 12:15 a.m., and only wanted a glass of ice water. Resident D stopped and watched the main entrance to the unit but went to his room on his own. Then at 1:00 a.m. the resident left his room, headed straight to the main door to the unit, and began attempting to open the door. The door alarm was sounding as the resident attempted to open it.

A Progress Noted, dated 12/27/21 at 11:52 a.m., indicated the nurse was notified, Resident D walked off of the unit late yesterday evening, after his wife had left. Resident D had followed his wife out the door. Staff immediately heard the alarm, after the door was opened, and watched the resident walk out the front lobby door.

A Progress Note, dated 12/26/21 at 11:20 p.m., indicated Resident D got out of the building that evening. After the resident's wife had left. The nurse was in a room taking care of another resident when other staff, said they had heard the alarm. The nurse went outside to the main door to find the resident walking back toward the door.

A Progress Noted, dated 12/26/21 at 5:49 a.m., indicated two-hour safety checks were done on Resident D, after he tried to open the Memory Care unit door.

A Progress Noted, dated 12/25/21 at 11:28 p.m., indicated Resident D's wife had left the unit at approximately 10:30 p.m. Resident D exited his room and walked straight toward the exit door of the unit. The resident pushed on the door long enough to open the door to the unit. Staff were able to stop the resident at the front desk before he exited the building. The resident was assisted to his apartment after much re-direction from staff. A CNA stayed by the door to the unit talking to another resident who was watching TV, when Resident D came out of his apartment, walked straight toward the CNA and began pushing buttons on the door keypad, he tried to get the CNA

to move away from the door so he could exit. The nurse returned to door and both staff members blocked the door from the resident. Resident D said, "all I have to do is push those buttons or push that door. Move and let me push that door."

A Progress Noted, dated 12/21/21 at 4:08 p.m., indicated Resident D was exit seeking and wandering since lunch. There was an incident when staff were standing by the exit door to keep him from exiting.

A Progress Noted, dated 12/18/21 at 11:28 a.m. indicated Resident D was found going out the front door.

A Progress Noted, dated 12/15/21 at 6:00 p.m., Resident D had been exit seeking most of the afternoon.

During an interview on 12/29/21 at 10:52 a.m., the Administrator indicated Resident D had been exit seeking and managed to get off the unit, into the main hall near the front doors, before staff retrieved him.

During an interview on 1/29/21 at 12:24 p.m., LPN 3 indicated Resident D had done a lot of exit seeking behaviors, he pushed on the doors until they opened, and pushed the numbers on the keypad to try to get out. He had made it off the unit before 12/13/21.

The current facility policy, "Resident Evaluation" and not dated, was provided by the Administrator on 12/29/21 at 10:00 a.m. The Policy indicated, " ...This community shall complete an evaluation of the individual needs of each resident ...to determine if the residents' health care needs can be adequately met by the facility ..."

The current facility policy, "Residents' Rights" and not dated, was provided by the Administrator on 12/29/21 at 10:00 a.m. The Policy indicated, " ...1. The right to a safe ...living environment ..."

The current facility policy, "Elopement Reminders/Procedures" and not dated, was provided by the Administrator on 12/29/21 at 10:00 a.m. The Policy indicated, " ...Staff are to have pagers on them while on shift ...if you get an alert on the MC pagers of a door being breached, please go to that door an investigate. Look outside/around to make sure a

resident has not gone out ..."

The current facility policy, "Elopement/Missing Resident" and not dated, was provided by the Administrator on 12/29/21 at 10:00 a.m. The Policy indicated, " ...personnel who have residents under their care are responsible for knowing the location of those residents ..."

This Residential tag relates to Complaint IN00368997.

Based on observation, interview, and record review, the facility failed to provide a safe environment for 3 of 4 residents reviewed for elopement resulting in a resident being found in a ditch by the road. (Residents B, C, and D)

Findings include:

1. The clinical record for Resident B was reviewed on 12/29/21 at 10:01 am. The resident's diagnoses included, but were not limited to, diabetes, hyperlipidemia, and a-fib. The resident was very confused and resided in a locked dementia unit.

A Progress Note, dated 12/13/21 at 7:15 a.m., indicated Resident B was found by staff, off of the unit. Reviewed video footage which found resident going out the door behind a family member, who had put the code in. Resident elopement

time was 5:43 p.m. By 5:45 p.m. staff began their search for the resident. Resident B was found in grassy area in front of building. Resident was assessed and escorted back into the building.

A Progress Note, dated 12/10/21 at 4:29 p.m., indicated Resident B had been exit seeking and hard to redirect.

A Progress Note dated 12/10/21 at 12:25 p.m., indicated Resident B had been exit seeking for a long period of time. He had figured out how to open the windows, and to pull them out completely. Items belonging to the resident were found outside a window and bought back in.

A Progress Note, dated 12/9/21 at 3:02 p.m.. indicated Resident B was agitated and exit seeking.

During an observation, interview, and record review on 12/29/21 at 10:28 a.m., the Administrator provided Incident Reports 9, 10, and 11. The Administrator indicated she had reviewed video from Incident 11 that occurred on 12/13/21 5:43 p.m. The video showed Resident B standing just around the corner, when a family member exited the Memory Care unit door. The video showed him run to get out the door before it closed, he ran

down the main hall, out the front door, down the hill, and was close to the road when staff located him. One staff member got in a car and drove down the hill and got him. She walked to the front entry door and pointed down the hill toward the main road by the facility. Observed a long curvy drive, with a side walk on the left, at the main road the sidewalk turned left, and approximately one tenth of a mile, ended with in a grassy area.

During an interview on 12/29/21 at 11:20 a.m., the Culinary Director indicated he was working on 12/13/21 and around 6:00 p.m. he was notified a resident was missing. He went out the back door and walked left toward the Villas. He was walking with the Wellness Director, from the right side of the building toward the front door, when he looked to his left and saw a car down on the road with its flashers on, so they went down to investigate. There was someone passing by and said they saw the resident fall, so they stopped, put on their flashers, and were calling 911. The Culinary Director indicated Resident B was observed with his feet in the ditch and his body on the grassy part. It was just past where the sidewalk ended. Resident B responded to his name, indicated he was ok, but was "just cold." The temperature

was in the high 40's or low 50's Fahrenheit, but it was after it rained so the ground was wet, soggy, and muddy. A nurse brought a car down and got him and returned him to the building.

During an interview on 12/29/21 at 12:18 p.m., LPN (licensed practical nurse) 2 indicated on 12/13/21, she had just come on shift and was getting report on the Assisted Living side, when she got the message on the radio, that Resident B had got out of the building. By the time she got down to the main floor, the Wellness Director had called on the radio, and asked her to get her car and come get the resident. She indicated at that time of night, around 6:00 p.m., it was really dark and the road was super busy. She indicated some people had stopped on the road and had their flashers on. She took her truck, went down, got Resident B into her truck, and returned him to the building.

During an interview on 1/29/21 at 12:24 p.m., LPN 3 indicated she was working on the Memory Care unit on 12/13/21. She had served dinner around 5:30 p.m. Around 5:45 p.m., she was in the kitchen area of the dining room cleaning up, when she saw Resident B talking to a CNA (certified nurse aide). LPN 3 indicated none of the staff had heard a door alarm, but

because the resident could not be easily located, staff did a room to room search. About that time, the Wellness Director called on the radio and said they had found him down by the main road.

During an observation on 12/29/21 at 12:35 p.m., the road in front of the facility was a four lane road with a center island, leading into a highly populated area, with several apartment communities, housing editions, several large churches, and a few businesses.

2. The clinical record for Resident C was reviewed on 12/29/21 at 11:21 a.m. The resident's diagnoses included, but were not limited to, depression, diabetes, dementia, and thyroid disease. The resident resided in a locked dementia unit.

A Progress Noted, dated 11/6/21 at 8:30 p.m., indicated Resident C had held the emergency handle down long enough, to open the exit door to stairway 5. She walked out of the building and straight across the drive to a Villa home. The Villa resident's caregiver took Resident C into the apartment and notified the main building. Resident C was returned to her apartment.

A Progress Noted, dated 8/4/21

9:19 p.m., indicated Resident C was trying to find the door so she could go home. Resident C held down the emergency handle on the main entrance door, of the Memory Care Unit, exited, and walked three feet outside of the door, into the main building hallway. The nurse was able to get the resident back on the unit.

A Progress Noted, dated 7/19/21 at 4:29 p.m., indicated Resident C was seen holding down on the emergency handle of the door, long enough until it opened, and proceeded out of it. Staff ran after her, following her out into the parking lot.

A Progress Noted, dated 7/3/21 at 4:20 a.m., indicated as staff were taking Resident C to bed, it was noticed the screen from the window was torn out. The staff looked closer and saw the window was open. The Wellness Director was alerted and found other rooms on the Memory Care unit with open windows.

A Progress Noted, dated 6/29/21 at 11:43 p.m., indicated Resident C was pacing the halls looking for an exit and pushed on the exit door a few times.

During an observation and interview on 12/29/21 at 10:46 a.m., the Administrator indicated Resident C had exited to the

	outside of the building, using the Stair 5 exit. The resident was going out toward the parking area, when a private caregiver in the villa across the street saw her, and at the same time, staff had heard the door alarm and caught up with her on the sidewalk just outside the door, and returned her to the building. Observed the sidewalk outside to lead to a parking area, with a street directly behind it, with another parking area, and the Villa Apartments across the street.			

During an interview on 12/29/21 at 12:18 p.m., LPN 2 indicated when Resident C got out of the building, she had exited through the Stair 5 exit door, and went across the street to the Villas, knocked on a door, and was let in. The caregiver for the Villa resident called to let the building know she had the resident, and wanted someone to come get her. LPN 2 indicated she went to the Memory Care unit. The Wellness Director told LPN 2, he had not heard the door alarm, because the room he was in had the TV up really loud. She stayed with the Memory Care residents while the Wellness Director went to get Resident C. The door alarms for the Memory Care unit are not usually heard in the main building. If you were on the main floor, near the front door, you might hear them.

3. The clinical record for Resident D was reviewed on 12/29/21 at 11:55 am. The resident's diagnoses included, but were not limited to, dementia, diabetes, and a-fib. The resident resided in a locked dementia unit.

A Progress Noted, dated 12/28/21 at 11:15 p.m., indicated Resident D attempted to exit the unit two times during the shift, between 6:00 p.m. and 8:00 p.m.

A Progress Noted, dated 12/28/21 at 12:50 p.m., indicated staff followed Resident D to the Memory Care door and watched as he tried to put in the code for the keypad, to allow the door to open.

A Progress Noted, dated 12/28/21 at 9:45 a.m., indicated Resident D had one episode of exit seeking that morning, right after breakfast.

A Progress Noted, dated 12/28/21 at 5:22 a.m., indicated two hour safety checks were done on Resident D, because he was trying to get out of the facility. The resident got up twice on night shift and both times tried to open the exit door. Staff were trying to redirect the resident while at the door, when the resident stated, "how do you get out of here? I know you have to put some numbers in."

A Progress Noted, dated 12/28/21 at 12:54 a.m., indicated Resident D ambulated on the unit from his room at approximately 12:15 a.m., and only wanted a glass of ice water. Resident D stopped and watched the main entrance to the unit but went to his room on his own. Then at 1:00 a.m. the resident left his room, headed straight to the main door to the unit, and began attempting to open the door. The door alarm was sounding as the resident

attempted to open it.

A Progress Noted, dated 12/27/21 at 11:52 a.m., indicated the nurse was notified, Resident D walked off of the unit late yesterday evening, after his wife had left. Resident D had followed his wife out the door. Staff immediately heard the alarm, after the door was opened, and watched the resident walk out the front lobby door.

A Progress Note, dated 12/26/21 at 11:20 p.m., indicated Resident D got out of the building that evening. After the resident's wife had left. The nurse was in a room taking care of another resident when other staff, said they had heard the alarm. The nurse went outside to the main door to find the resident walking back toward the door.

A Progress Noted, dated 12/26/21 at 5:49 a.m., indicated two-hour safety checks were done on Resident D, after he tried to open the Memory Care unit door.

A Progress Noted, dated 12/25/21 at 11:28 p.m., indicated Resident D's wife had left the unit at approximately 10:30 p.m. Resident D exited his room and walked straight toward the exit door of the unit. The resident pushed on the

door long enough to open the door to the unit. Staff were able to stop the resident at the front desk before he exited the building. The resident was assisted to his apartment after much re-direction from staff. A CNA stayed by the door to the unit talking to another resident who was watching TV, when Resident D came out of his apartment, walked straight toward the CNA and began pushing buttons on the door keypad, he tried to get the CNA to move away from the door so he could exit. The nurse returned to door and both staff members blocked the door from the resident. Resident D said, "all I have to do is push those buttons or push that door. Move and let me push that door."

A Progress Noted, dated 12/21/21 at 4:08 p.m., indicated Resident D was exit seeking and wandering since lunch. There was an incident when staff were standing by the exit door to keep him from exiting.

A Progress Noted, dated 12/18/21 at 11:28 a.m. indicated Resident D was found going out the front door.

A Progress Noted, dated 12/15/21 at 6:00 p.m., Resident D had been exit seeking most of the afternoon.

During an interview on 12/29/21

at 10:52 a.m., the Administrator indicated Resident D had been exit seeking and managed to get off the unit, into the main hall near the front doors, before staff retrieved him.

During an interview on 1/29/21 at 12:24 p.m., LPN 3 indicated Resident D had done a lot of exit seeking behaviors, he pushed on the doors until they opened, and pushed the numbers on the keypad to try to get out. He had made it off the unit before 12/13/21.

The current facility policy, "Resident Evaluation" and not dated, was provided by the Administrator on 12/29/21 at 10:00 a.m. The Policy indicated, " ...This community shall complete an evaluation of the individual needs of each resident ...to determine if the residents' health care needs can be adequately met by the facility ..."

The current facility policy, "Residents' Rights" and not dated, was provided by the Administrator on 12/29/21 at 10:00 a.m. The Policy indicated, " ...1. The right to a safe ...living environment ..."

The current facility policy, "Elopement Reminders/Procedures" and not dated, was provided by the Administrator on 12/29/21 at

	10:00 a.m. The Policy indicated, " ...Staff are to have pagers on them while on shift ...if you get an alert on the MC pagers of a door being breached, please go to that door an investigate. Look outside/around to make sure a resident has not gone out ..." The current facility policy, "Elopement/Missing Resident" and not dated, was provided by the Administrator on 12/29/21 at 10:00 a.m. The Policy indicated, " ...personnel who have residents under their care are responsible for knowing the location of those residents ..." This Residential tag relates to Complaint IN00368997.			

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