STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/03/2023

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 a Post Survey Revisit (PSR) to a Complaint Investigation completed on December 21, 2022. Complaint IN00391651 - Not corrected Survey date: February 3, 2023 Facility number: 015179 Residential Census: 66 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on February 8, 2023.	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:** The resident was placed on a 1:1 supervision until exhibiting no signs of exit seeking during incident. Resident identified as "high risk" for elopement and	

			Care Plan was updated to identify this risk. Family and Physician made aware. -Completed 1/31/22 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 memory care director will continue to identify residents 'at risk' for elopement upon admission and with each care plan/ assessment thereafter. The documentation of screening will be kept in the resident's medical chart.	

			Residents that are identified as high risk will have such findings on their face sheet of care plan as well as name will be added to the elopement list at our nursing care base. -Completed 2/1/23 and ongoing **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. The documentation of screening will be kept in the resident's medical chart. -Completed 2/1/23 and ongoing monthly The Executive Director will	

			conduct an Inservice for employees to review elopement policy and procedures. The Executive Director will retain documentation of the Inservice. -Completed 2/27/23 An elopement drill will happen every month to train staff on elopement response. Documentation of drills will be obtained by Executive Director. Completed 2/24/23 and ongoing monthly. 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 2/1/23 and ongoing **What date the systemic changes will be**	

			completed: 2/27/23 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 1 of 3 residents reviewed for elopement. (Resident C) Findings include: The clinical record for Resident C was reviewed on 2/3/23 at 11:05 a.m. The diagnoses included, but were not limited to, dementia, tremor, and hypertension. A nursing note, dated 1/24/23 at	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:** **(1) Sexual Abuse;**	02/27/2023

7:41 p.m., indicated an as needed Lorazepam (an antianxiety medication) was administered due to Resident C exit seeking, pacing halls, and asking when it was time to leave.

A nursing note, dated 1/26/23 at 10:00 p.m., indicated Resident C was running up and down the hallways, was out of breath, and unsteady; but refused to stop running and trampled into staff. When the staff tried to redirect the resident out of other residents' rooms, he had become aggressive.

A nursing note, dated 1/28/23 at 5:44 p.m., indicated when the nurse came on shift, Resident C was running all over the unit, up and down the halls and was unable to be redirected.

A nursing note, dated 1/31/23 at 4:51 p.m., indicated Resident C had an elopement that evening. The resident was escorted back to the building by a villa resident, after being found running in the villa court.

During an interview on 2/3/23 at 10:45 a.m., the Administrator indicated there was another elopement occurred a few days ago. A pipe burst in the locked unit and there was a contractor doing the repairs. They were bringing supplies in through the back door of the dementia unit,

(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:

The resident was placed on a 1:1 supervision until exhibiting no signs of exit seeking during incident.
Resident identified as "high risk" for elopement and Care Plan was updated to identify this risk.
Family and Physician made

	and Resident C had gotten out. He went to the left out of the building, turned left again toward the front of the building. A staff member had intercepted him and brought him in through the front door. He was only outside maybe two minutes. An Incident Report was provided by the Administrator on 2/3/23 at 11:04 a.m. The report indicated on 1/31/23 at 3:15 p.m. Resident C had eloped off the memory care unit. The resident went out of a door as someone was carrying something in. An Independent Living Resident had redirected the resident back on to the unit. An Elopement Investigation for Resident C, dated 1/31/23, was provided by the Administrator on 2/3/23 at 11:50 a.m. The report indicated the resident was cognitively impaired with poor decision-making skills, ambulated without assistance, and was a wanderer, and oblivious to physical and safety needs. The area had alarmed doors and they were working properly. The facility had identified a deficient practice placing the resident at risk because another resident (Resident E) was at the alarming door and staff assisted Resident E back and failed to do a headcount to ensure every resident was accounted for.		aware. -Completed 1/31/22 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 memory care director will continue to identify residents ‘at risk’ for elopement upon admission and with each care plan/ assessment thereafter. The documentation of screening will be kept in the resident’s medical chart. Residents that are identified as high risk will have such findings on their face sheet of care plan as well as name will be added to the elopement list at our nursing care base.	

	An Assessment for Resident C, dated 12/13/22 was provided by the Administrator on 2/3/23 at 12:42 p.m. The assessment indicated he was independent in mobility and wandered with exit seeking behavior. During an interview on 2/3/23 at 12:20 p.m., Licensed Practical Nurse (LPN) 2 indicated Resident C had elopement behaviors; he literally ran from door to door. During an observation and interview on 2/3/23 at 12:36 p.m., the Administrator indicated an Independent Living resident was the one that saw Resident C first and redirected him back to the building; where the Administrator was going out the front door and they met in the lobby. The Surveyor reviewed a video, dated 1/31/23 at 3:13 p.m., where Resident C was walking from behind the building to the left toward the villa apartments, where he turned left toward the front of the building. The Independent Living resident saw him and walked with him toward the front door at 3:19 p.m. During an interview on 2/3/23 at 12:52 p.m., the Administrator indicated she was made aware of Resident C being out of the building when the Independent Living resident brought him into the front entrance of the		-Completed 2/1/23 and ongoing **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. The documentation of screening will be kept in the resident's medical chart. -Completed 2/1/23 and ongoing monthly The Executive Director will conduct an Inservice for employees to review elopement policy and procedures. The Executive Director will retain documentation of the Inservice. -Completed 2/27/23	

	building. During an interview on 2/3/23 at 1:02 p.m., LPN 4 indicated on 1/31/23 there was a construction crew that had the code to the back door, so they could go in and out for supplies. She heard the alarm and went to that hallway where she saw Resident E coming from that direction. She took that resident back to the main part of the unit and went back to the back door. There were three non-English speaking construction workers bringing in supplies and she held the door for them. She saw Resident E going in and out of rooms, so she ran to get her a second time. That was when she got a call saying they needed a nurse up front, and that was when she realized Resident C was out of the locked dementia unit. During an interview on 2/3/23 at 1:22 p.m., CNA (Certified Nurse Aide) 5 indicated on 1/31/21 she had on a pager and walkie-talkie. She was making a bed in Room 111 when Resident C had gotten out of the facility. She never heard the door alarm going off. She then went to Room 154 to make the bed, heard people talking in the hall, stepped out and they said Resident C had gotten out. The nurse told her, she did not do a head count at that time. CNA 5 indicated she did get a page		An elopement drill will happen every month to train staff on elopement response. Documentation of drills will be obtained by Executive Director. Completed 2/24/23 and ongoing monthly. 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 2/1/23 and ongoing **What date the systemic changes will be completed:** 2/27/23 and ongoing	

	saying the back door was alarming, but no one said anything on the walkie talkie, so she was unaware there was anyone missing from the unit. During an interview on 2/3/23 at 1:26 p.m., the Maintenance Director indicated the construction company employees had been in and out of the building for a couple of days prior to the elopement. He gave them the code to the back door and told them to make sure no resident was near the door when entering or exiting; if there was a resident at the door, they were to contact staff and the staff would escort the resident back away from the door. He showed them how to reset the alarm when it went off. As soon as the alarm went off it would alert the staffs pagers. There was no staff assigned to watch the doors that day while the construction crew was on site. The current facility policy, "Elopement," and dated 6/14, was provided by the Administrator on 2/3/23 at 11:04 a.m. The Policy indicated, " ...It is the policy of this facility to maintain the safety of all residents..."			

This deficiency was cited on 12/21/22. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on observation, interview, and record review, the facility failed to provide a safe environment for 1 of 3 residents reviewed for elopement. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 2/3/23 at 11:05 a.m. The diagnoses included, but were not limited to, dementia, tremor, and hypertension.

A nursing note, dated 1/24/23 at 7:41 p.m., indicated an as needed Lorazepam (an antianxiety medication) was administered due to Resident C exit seeking, pacing halls, and asking when it was time to leave.

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nurse came on shift, Resident C was running all over the unit, up and down the halls and was unable to be redirected.

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During an interview on 2/3/23 at 10:45 a.m., the Administrator indicated there was another elopement occurred a few days ago. A pipe burst in the locked unit and there was a contractor doing the repairs. They were bringing supplies in through the back door of the dementia unit, and Resident C had gotten out. He went to the left out of the building, turned left again toward the front of the building. A staff member had intercepted him and brought him in through the front door. He was only outside maybe two minutes.

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An Elopement Investigation for Resident C, dated 1/31/23, was provided by the Administrator on 2/3/23 at 11:50 a.m. The report indicated the resident was cognitively impaired with poor decision-making skills, ambulated without assistance, and was a wanderer, and oblivious to physical and safety needs. The area had alarmed doors and they were working properly. The facility had identified a deficient practice placing the resident at risk because another resident (Resident E) was at the alarming door and staff assisted Resident E back and failed to do a headcount to ensure every resident was accounted for.

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she got a call saying they needed a nurse up front, and that was when she realized Resident C was out of the locked dementia unit.

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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