STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERCREST SENIOR LIVING	4917 GRANT LINE ROAD, NEW ALBANY, , 47150

(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 IN00463650. Intake IN00463650 - State deficiency related to the allegations is cited at R0052. Survey date: August 18, 2025 Facility number: 015516 Residential Census: 42 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on August 19, 2025.	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;	R 0052	This plan of correction is to serve as Rivercrest Residential Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rivercrest Residential Campus or its management company that the allegations contained in the survey	08/26/2025

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on record review, observation, and interview, the facility failed to ensure a resident who resided in a locked unit was secured during an activity for 1 of 3 residents reviewed for neglect. (Resident B)

Findings include:

The State reported incident, dated 7/26/25 at 4:02 p.m., indicated the Activities Director was assigned to escort 11 residents out from the dementia unit to Happy Hour in the Assisted Living Lobby area. At the conclusion of the activity, Resident B had exited the facility when a visitor entered the building. Resident B was located shortly after and returned to the facility unharmed.

The written statement, dated 7/26/25, by Certified Nurse Aide (CNA) 4 indicated the CNA returned from her meal break at 3:10 p.m. and the activity had already started in the lobby/main dining room. The CNA brought one last resident

report are a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for Rivercrest Residential Campus annual survey that was completed on. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is: 8/26/2025. We initiated immediate interventions when concerns were identified during recertification survey.

If you need any information or paperwork, please contact me at 1(502)-243-5744.

Sincerely, Mark Adkins, Administrator.

R052 Resident Rights

*What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;

*The affected resident experienced no adverse outcomes and no longer resides at the facility.

	out from the dementia unit for the activity and sat down near them. The CNA left to talk to a nurse while the entertainer finished his last song. Once the song was finished CNA 4 and Activities Assistant 6 gathered the residents from the dementia unit (in the lobby/main dining room) to bring them back to the unit. On the way back to the unit, the CNA stopped to take a resident to the public restroom. The CNA let Activities Assistant 6 know what she was doing. She then assisted the remaining residents back to the dementia unit. The written statement, dated 7/26/25, by LPN 5 indicated she was back and forth between the area with music and her medication cart. LPN 5 observed Activities Assistant 6 and the CNA 4 take the residents back to the dementia unit. At 4:13 p.m., a call was made to the facility by someone at a neighboring house informing them that a resident was at their house. LPN 5 and CNA 4 located Resident B and returned her back to the facility. The written statement, dated 7/26/25, by Activities Assistant 6 indicated she escorted Resident B and 10 other residents around 2:55 p.m. from the dementia unit to Happy Hour in the lobby/dining room. The music concluded at 3:50 p.m., and she		*How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; *All residents have the potential to be affected by the deficient practice. *All residents in both memory care and assisted living underwent a one-time audit conducted by the campus Director of Health Services or their designee immediately following the event, through an elopement risk observation, which was used to identify similar resident profiles. Residents identified as having a risk for elopement or wandering were reviewed to confirm appropriate placement, and interventions were incorporated into service plans to address these risks. On 8/25/2025, Clinical Support reviewed all residents in memory care and assisted living to verify that current elopement risk and exit-seeking observations are up to date and accurate. It was confirmed that all residents determined to be at risk of elopement or exit-seeking have service plans addressing this risk appropriately. * The elopement binder was reviewed on 7/28/2025 and on 8/28/25 by Clinical Support to confirm resident identification	

	began gathering the residents from the dementia unit. Activities Assistant 6 had been sitting in the middle of the dining area and when she stood up, it might have been difficult to visualize Resident B. She did remember Resident B sitting in the corner with someone nearby. This was her first time to oversee residents out from the dementia unit to an activity in the assisted living area. A timeline of events for Resident B leaving the front door of the facility, indicated the Resident Care Aide (RCA) 3 received the call about the resident being found by the homeowner behind the facility at 4:13 p.m. He informed CNA 4 who then informed Licensed Practical Nurse (LPN) 5. Both staff left the building at 4:19 a.m. and retrieved Resident B from the nearby home. The Executive Director (ED) reviewed the video surveillance footage and Resident B had left the facility, through the front door at 4:00 p.m.		complied with Trilogy's policy for those "at risk" of elopement or exit-seeking. There were no findings of noncompliance noted. *An elopement drill took place on during the initial investigation of the event, during the first shift, led by the director of plant operations. No issues were identified with staff response during the drill. *What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur; * During the initial investigation of the event, the Trilogy Health Services Assistant VP of Clinical Services re-educated DHS, ED, and LED on policies related to missing residents, changes in condition, happy hour, resident elopement risk, outings, and new supervision rules for legacy residents. Clinical Support provided follow-up training to the Administrator, Director of Health Services, and Life Enrichment Director on 8/19/25 regarding these procedures and confirmed the team's understanding according to Trilogy policy. * Once the Administrator, Director of Health Services and Life Enrichment Director were provided with re-education, the Director of Health Services and/or designee provided the above referenced	

	The clinical record for Resident B was reviewed on 8/18/25 at 8:20 a.m. The resident's diagnoses included, but were not limited to, a history of rhabdomyolysis, falls, macular degeneration, intervertebral lumbar disc degeneration, type 2 diabetes mellitus, and hospice services. The Admission Minimum Data Set (MDS) assessment, dated 7/22/24, indicated the resident was severely cognitively impaired. The physician's order, dated 7/22/24, indicated the resident was to be placed in a secured locked unit. The order was discontinued on 7/26/25, when the resident started a leave of absence with the resident's family and subsequent discharged in the care of family. During an interview, on 8/18/25 at 8:55 a.m., LPN 7 indicated the staff observed the residents for exit seeking from the dementia unit. A resident would self-direct themselves if the door wouldn't open when they pushed on it. If the resident didn't self-direct, then staff would redirect the resident. For an activity outside of the dementia unit, the Activities Assistant would come to the unit to walk the resident to the activity. A CNA would sometimes go with the residents		education to both nursing and life enrichment staff. This education was initiated and completed during the initial investigation of the event and again initiated on 8/19/2025 and completed on 8/26/2025. *Any newly hired nursing and/or life enrichment staff hired after 8/19/2025 will be provided with the above referenced education and post test during their general orientation and onboarding. *How will corrective actions be monitored to prevent recurrence, and what quality assurance measures will be implemented? *This deficient practice has been added to the ongoing Quality Assurance Meeting. The Quality Assurance meeting is held monthly with the Medical Director in attendance. The QAPI monitoring plan implemented to minimize the risk for re-occurrence. * As part of the facility's quality improvement plan, the Administrator or Director of Health Services will interview three staff members each week for four weeks, then monthly for five months, about monitoring residents at risk for elopement during activities. This ensures staff understand procedures for safely supervising and returning these residents as per updated policy. No deficiencies have been identified in	

	also. While the activity was going on, the Activity Assistant would monitor the residents, or the CNA would be with the residents to watch them for attempts to leave the building. LPN 7 wasn't working when Resident B left the building. After the resident had eloped, a new policy was put into place for elopement. The Director of Nursing (DON) also conducted training where she hid, and the staff were asked to find her. If a resident was discovered to be missing, an overhead announcement would now indicate a call for the resident and the staff would start the process for a search. During an observation, on 8/18/25 at 8:57 a.m., 12 residents were sitting in the Dementia Unit's Dining Room, eating breakfast. One resident was lying on the sofa in the sitting area. During an interview, on 8/18/25 at 10:24 a.m., the Executive Director (ED) and DON indicated that Resident B was taken to the dining room to watch a musician. Resident B managed to go out the front door as residents were being gathered to take back to the dementia unit. Activities Assistant 6 was sitting with the residents from the unit. RCA 3 received a call from a homeowner behind the facility.		ongoing staff interviews. * As part of the facility's ongoing quality improvement plan, the Administrator, Life Enrichment Assistance, Director of Health Services and/or designee will observe the weekly happy hour for 6 months to ensure residents escorted to and from the legacy way unit are properly supervised and accounted for in accordance with Trilogy's policy and procedures. No deficiencies have been identified during ongoing observations. * Audit results will be reviewed at monthly QAPI meetings to decide if ongoing monitoring remains necessary. If 100% compliance is observed, monitoring may end. The Administrator will oversee the process to ensure residents' wellbeing and address facility concerns with corrective action plans. Date of compliance 8/26/2025	

	The homeowner informed RCA 3 that they thought there might be a resident from the facility at their house and indicated the person's first name, which was Resident B's name. The staff member let CNA 4 know, and she then let LPN 5 know. There weren't any dividers between the facility and the homeowner's house, which was in the neighborhood next to the facility. There was a strip of land between the neighborhood and the facility. It went uphill and used to be a railroad track. Resident B did not have any injuries upon return to the facility. The day was sunny and in the 80s or higher, but there was no severe weather. Prior to this, the entertainment wasn't usually done on the weekends. The staff member at the front desk and management were normally there on the weekdays, but not on the weekends. The new interventions were for a sign-out sheet to be with the activity person to check off the residents from the dementia unit throughout the activity. No special weekend event will be held from now on. They would have immediately known that Resident B was missing if the check-off list had been in place. The resident didn't typically drink alcohol and had not had any alcohol during the activity. Residents were being served lemonade.				

The review of the weather history for 7/26/25 at 4:00 p.m., indicated the outside temperature was 92 degrees Fahrenheit (F)

The review of the map provided by the facility, indicated the suspected path that the resident took from the facility to the neighboring house. The resident had crossed a busy road to get to the house the homeowner called from.

An observation, on 8/18/25 at 10:55 a.m., of the location behind the facility there was a grassy uphill climb to an abandoned railroad, approximately 20 to 30 feet distance. This the was the direction the facility implied the resident went.

The Guidelines: Elopement Risk Assessment and Prevention policy, reviewed 12/17/24, included, but was not limited to, " ... These policies assist to define the mechanisms and procedures for monitoring and managing residents at risk for elopement help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision ... Procedure 1. Each resident will be assessed for elopement risk upon admission, quarterly, and with change in condition ... 3. A plan of care will be developed and implemented for

each resident identified as having the potential to leave the facility unauthorized, requiring supervision for off ground privileges or wandering to an unsafe area ... 9. Activity programs should include plans for diversion and redirection during periods of increased wandering and exit seeking ..."

This citation relates to Intake IN00463650

Based on record review, observation, and interview, the facility failed to ensure a resident who resided in a locked unit was secured during an activity for 1 of 3 residents reviewed for neglect. (Resident B)

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The written statement, dated 7/26/25, by Certified Nurse Aide (CNA) 4 indicated the CNA returned from her meal break at

3:10 p.m. and the activity had already started in the lobby/main dining room. The CNA brought one last resident out from the dementia unit for the activity and sat down near them. The CNA left to talk to a nurse while the entertainer finished his last song. Once the song was finished CNA 4 and Activities Assistant 6 gathered the residents from the dementia unit (in the lobby/main dining room) to bring them back to the unit. On the way back to the unit, the CNA stopped to take a resident to the public restroom. The CNA let Activities Assistant 6 know what she was doing. She then assisted the remaining residents back to the dementia unit.

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A timeline of events for Resident B leaving the front door of the facility, indicated the Resident Care Aide (RCA) 3 received the call about the resident being found by the homeowner behind the facility at 4:13 p.m. He informed CNA 4 who then informed Licensed Practical Nurse (LPN) 5. Both staff left the building at 4:19 a.m. and retrieved Resident B from the nearby home. The Executive Director (ED) reviewed the video surveillance footage and Resident B had left the facility, through the front door at 4:00 p.m.

The clinical record for Resident B was reviewed on 8/18/25 at 8:20 a.m. The resident's diagnoses included, but were not limited to, a history of rhabdomyolysis, falls, macular

degeneration, intervertebral lumbar disc degeneration, type 2 diabetes mellitus, and hospice services.

The Admission Minimum Data Set (MDS) assessment, dated 7/22/24, indicated the resident was severely cognitively impaired.

The physician's order, dated 7/22/24, indicated the resident was to be placed in a secured locked unit. The order was discontinued on 7/26/25, when the resident started a leave of absence with the resident's family and subsequent discharged in the care of family.

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LPN 7 wasn't working when Resident B left the building. After the resident had eloped, a new policy was put into place for elopement. The Director of Nursing (DON) also conducted training where she hid, and the staff were asked to find her. If a resident was discovered to be missing, an overhead announcement would now indicate a call for the resident and the staff would start the process for a search.

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	programs should include plans for diversion and redirection during periods of increased wandering and exit seeking ..." This citation relates to Intake IN00463650			

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