STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00410792. Complaint IN00410792 - No deficiencies related to allegation are cited. Unrelated deficiency is cited. Survey date: July 28 and 31, 2023 Facility number: 005722 Residential Census: 79 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed August 2, 2023.	R 0000	The submission of the Plan of Correction does not indicate an admission by Independence Village of Greenwood that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of Independence Village of Greenwood. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the credible allegation of compliance with all State requirements governing the operations of this Community.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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 interview and record review, the facility failed to protect the residents right to be free from neglect for 3 of 3 residents reviewed for elopement. Three residents who reside on the secured memory care unit exited the facility without supervision. This deficient practice resulted in one resident exiting the facility twice	R 0052	1. Resident “B” no longer resides in the Community. Residents’ “C” was assessed for pain or injury post event on 7/11/2023. No negative findings. Resident “D” was assessed for pain and injury post event on	07/31/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Y Rumple	Administrator	08/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	and two residents were found next to a busy highway. (Resident B, Resident C, Resident D) Finding includes: 1. During an interview on 7/28/23 at 8:50 a.m., the Administrator indicated she watched camera footage after Resident B and Resident C exited the facility through the southwest entrance on the secured memory care unit. On 7/11/23 at 6:44 a.m., a door alarm was sounding on the memory care unit. CNA 1 (Certified Nurse's Aide) walked up to the door where the alarm was sounding, and turned off the alarm while Resident B and Resident C were outside. CNA 1 did not open the door to see if any resident exited the building. CNA 1 should have opened the door to check for any residents that may have exited the facility. CNA 2 saw Resident B and Resident C standing on the sidewalk approximately 15 feet from a busy main road. During an interview on 7/28/23 at 9:30 a.m., CNA 2 indicated on 7/11/23 at approximately 6:47 a.m., she pulled onto the road that leads to the parking lot of the facility. She saw Resident B and Resident C on the sidewalk near a busy main road outside the facility. CNA 2 stopped her car and assisted Resident B and Resident C into her car. She drove the residents to the entrance of the main memory care unit entrance and took the residents inside the facility. Neither Resident B nor Resident C had shoes on, and Resident C was "completely soaked with urine." During an interview on 7/28/23 at 11:55 a.m., the DON (Director of Nursing) indicated she watched the video footage when Resident B and Resident C exited the facility. Resident B was standing at the southwest entrance and Resident C was		7/28/2023. No negative findings. Both residents' "C" and "D". have had their respective service plans updated with interventions. 2. The Community realizes that other residents could have the potential to be affected by the alleged deficient practice. All service plans have been reviewed and updated as appropriate. 3. Staff were re-educated on 7/11/2023 regarding the sounding of an alarmed door on the Memory Care neighborhood and the necessity to go out the door to see if any resident(s) had eloped. Other staff will conduct a head count to ensure all residents have been accounted for in the Memory Care Neighborhood. On 7/28/2023, all shifts were re-educated regarding our monthly drills on Turn and Push and Elopement. Both drills are conducted monthly on each shift. It should be noted that the Turn and Push drill intent is to educate all staff on how we enter and exit the Memory Care doors, ensuring that they are locked and secure. 4. Residents with documented behaviors will be reviewed daily by the Wellness Director/designee and then given to the Executive Director for review and recommendations up to and including transfer or discharge if the resident poses a threat to themselves or others. Resident will placed on scheduled	

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	sitting in her wheelchair next to Resident B. Resident B started pushing on the door. Once the door was open, Resident B turned around, held the door open, and pulled Resident C, in her wheelchair, outside. After approximately 5 minutes of the alarm sounding, CNA 1 walked up and turned off the alarm but did not open the door to look outside for any residents. During an interview on 7/31/23 at 9:20 a.m. QMA 1 indicated she was the QMA working when Resident B and Resident C exited the facility. She was made aware of the elopement when a manager called her and told her CNA 2 found the residents outside and put both residents in her car. She immediately ran outside and saw CNA 2, Resident B standing outside the car, and Resident C sitting in the backseat of the car. She assisted CNA 2 and both residents back into the facility. QMA 1 happened to be on the secured memory care unit when she received the phone call from the manager that notified her of the elopement. CNA 1 never made her aware of the alarm that sounded nor that residents were not on the unit. The clinical record for Resident B was reviewed on 7/28/23 at 11:26 a.m. The diagnoses included, but were not limited to, dementia, Alzheimer's disease, and history of falls. A Brief Cognitive Rating Scale, dated 6/2/23, indicated Resident B had severe cognitive decline. An Elopement Risk Evaluation, dated 6/4/23, indicated Resident B was at risk for elopement. A Service Plan, dated 4/7/23 and current through 7/6/23, indicated Resident B's service plan was revised, on 7/11/23, after Resident B eloped, to include Resident B was an elopement risk. Also		monitoring/1:1 until the appropriate arrangements can be made. The Wellness Director/designee will audit the findings and forward them to the monthly Quality Assurance Process Improvement Committee for six (6) months or until 100% compliance is achieved X three (3) consecutive months. The QAPI Committee will review and make any recommendations necessary.	

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	initiated, on 7/11/23, were interventions that included ensure Resident B was maintained in sight during programs, ensure Resident B or the responsible party sign out when leaving the community with expected time of return, and monitor Resident B's whereabouts to ensure Resident B remains in the facility. An undated incident report indicated upon pulling into the parking, lot CNA 2 noted Resident B outside the facility pushing Resident C. CNA 2 took the residents back to the secured memory care unit in her car. The clinical record for Resident C was reviewed on 7/28/23 at 11:09 a.m. The diagnoses included, but were not limited to, dementia, anxiety disorder, and major depression. A Brief Cognitive Rating Scale, dated 6/8/23, indicated severe cognitive decline An undated incident report indicated upon pulling into the parking lot CNA 2 noted Resident C outside the facility in her wheelchair. CNA 2 put Resident C in her car and drove to the secure memory care unit entrance. Resident C was wheelchair bound and unable to push the doors open without assistance. A corrective action form, dated 7/11/23, indicated CNA 1 was suspended because CNA 1 failed to appropriately respond to a door alarm, failed to check perimeter for any residents, shut off the alarm which allowed two residents to leave the building. CNA 1 was sitting in the memory care dining room for most of the shift playing on a cellphone. During an interview on 7/28/23 at 2:27 p.m., the			

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	Administrator indicated the service plan, dated 4/7/23, is the most up to date service plan for Resident B. The service plan for Resident C could not be located. During an interview on 7/28/23 at 3:45 p.m., the DON indicated elopement risk assessments were not supposed to be completed on every resident in the facility because all of the residents who resided on the secured memory care unit were considered at risk elopement. The service plan for Resident B should have been updated according to the elopement risk assessment. 2. During an interview on 7/28/23 at 12:18 p.m., QMA 2 indicated Resident B and Resident D went outside the facility early that morning (7/28/23) at approximately 5:00 a.m. During an interview on 7/28/23 at 12:50 p.m., the Memory Care Director indicated Resident B and Resident D went outside the facility on the previous shift. During an interview on 7/28/23 at 12:56 p.m., CNA 3 indicated Resident B and Resident D walked outside on the previous shift. She believed CNA 4 was the CNA that brought the residents back into the facility. During an interview on 7/31/23 at 9:00 a.m., CNA 4 indicated she was working when Resident B and Resident D went outside the facility. She heard a door alarm at the southwest door and immediately ran to the door. Resident B and Resident D were standing at the door pushing on it. CNA 4 ran to the door and redirected both residents. CNA 4 was not able to shut off the door alarm, so she left the unit to get another CNA to shut off the alarm. The door alarm was shut off when CNA 4 returned			

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	to the unit with the other CNA. Once the alarm was shut off, CNA 4 heard the south door alarm sounding. When CNA 4 went to check the south door, a door bell range for the southwest door. When the southwest door was opened, Resident B and Resident D were standing outside. CNA 4 thought other staff were watching Resident B and Resident D. The clinical record for Resident B was reviewed on 7/28/23 at 11:26 a.m. The diagnoses included, but were not limited to, dementia, Alzheimer's disease, and history of falls. A Brief Cognitive Rating Scale, dated 6/2/23, indicated Resident B had severe cognitive decline. An Elopement Risk Evaluation, dated 6/4/23, indicated Resident B was at risk for elopement. A Service Plan, dated 4/7/23 and current through 7/6/23, indicated Resident B's service plan was revised, on 7/11/23, after Resident B eloped, to include Resident B was an elopement risk. Also initiated, on 7/11/23, were interventions that included ensure Resident B was maintained in sight during programs, ensure Resident B or the responsible party sign out when leaving the community with expected time of return, and monitor Resident B's whereabouts to ensure Resident B remains in the facility. The clinical record for Resident D was reviewed on 7/28/23 at 2:48 p.m. The diagnoses included, but were not limited to, dementia, diabetes, and anxiety disorder. An undated incident report indicated Resident D exited the facility with Resident B. Resident B and Resident D were found attempting to get back into			

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	the facility. On 7/28/23 at 8:50 a.m., the Administrator provided a copy of a facility, titled Elopement, and dated 8/31/20. A review of the policy indicated it is the policy that immediate and appropriate action is taken when a resident is identified as missing, or an elopement has occurred.			