STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155838	A. BUILDING 00 B. WING	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00401211. Complaint IN00401211 - Substantiated. State deficiencies related to the allegations are cited at R0052. Survey date: February 17, 2023 Facility number: 013409 Residential Census: 71 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 22, 2023.	R 0000	**Plan of Correction FOR Stonecroft HEALTH CAMPUS** **R052 INITIAL COMMENTS** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted February 17, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 3, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Bales	Clinical Support RN	03/03/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155838	A. BUILDING 00 B. WING	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview and record review, the facility failed to protect the residents right to be free from neglect for 1 of 1 residents reviewed for elopement. A resident exited the secured dementia unit and was found outside. (Resident B) Finding includes: The clinical record of Resident B was reviewed on 2/17/23 at 10:30 a.m. The diagnoses included, but were not limited to, unspecified dementia without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety. Resident B's Service Plan indicated he was a risk for elopement. Resident B had wandering concerns and was independent walking using a rolling walker. During an interview with the Administrator on 2/17/23 at 11:16 a.m., indicated the root cause of Resident B's elopement from a secured unit was due to a red button being hit on the 200 hall nurses station instead of a green button. She indicated the green button would only open the front door for the lab or any visitor after hours, however, the red button unlocked all the doors in the facility, including the secured unit. On 2/17/23 at 11:45 a.m., the timeline of events, provided by the DHS (Director of Health Services) from 2/7/23 was reviewed. The timeline indicated Resident B was checked on in his room at approximately 2:00 a.m. on 2/7/23, and was asleep. At approximately 2:21 a.m., a CRCA (Certified Registered Care Assistant) entered Resident B's room to remove the trash, and he was not there. The CRCA notified the night supervisor and a	R 0052	**Tag R052 – Resident Rights** *"Facility failed to protect the residents right to be free from neglect for 1 of 1 residents reviewed for elopement. A resident exited the secured dementia unit and was found outside."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident #1 was assisted into the building with no injury or psychosocial issues noted. - A plastic cover was placed over the red and green buttons to prevent further use of the red button. The red button unlocks all of the doors in the facility. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. - A plastic cover was placed over the red and green buttons to prevent further use of the red button. The red button unlocks all the doors in the facility. - Education was provided to all staff by the DHS/ADHS. Education provided: o Elopement Policy	03/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155838	A. BUILDING 00 B. WING	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	search was initiated. At 2:27 a.m., Resident B was seen by EMS and the CRCA standing outside a locked side door that lead to the facility sidewalk. This State tag relates to Complaint IN00401211.		o Red and green button usage **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DPO/designee will complete monitoring 3 times a week for 4 weeks to ensure the cover remains on the red and green buttons and the legacy doors remain secured, every other week for 2 months, then monthly in QAPI for 3 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. **5. Date of completion:** 03/03/2023	