STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING _____ B. WING _____	C 04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN 46107

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F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00456658, IN00456962, and IN00457689. This visit resulted in a Partially Extended Survey-Substandard Quality of Care- Immediate Jeopardy.

Complaint IN00456658 - No deficiencies related to the allegations are cited.

Complaint IN00456962 - No deficiencies related to the allegations are cited.

Complaint IN00457689 - Federal/State deficiencies related to the allegations are cited at F689.

Survey dates: April 24, 25, and 28, 2025

Facility number: 000029
Provider number: 155072
AIM number: 100275200

Census Bed Type:
SNF/NF: 86
SNF: 7
Residential: 6
Total: 99

Census Payor Type:
Medicare: 7
Medicaid: 68
Other: 18
Total: 93

This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 000	Continued From page 1 Quality review completed April 29, 2025.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision to a resident that resided on the secured memory unit and had a history of exit seeking behaviors, from exiting the facility through a window in his room. The day of the elopement the resident was angry, exit seeking, trying to leave, stated he needed out of there. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 4/15/25 at approximately 6:20 p.m., when the facility failed to provide supervision to a cognitively impaired resident, that resided on the memory care unit, to prevent an elopement. The Administrator, Director of Nursing, Assistant Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 4/24/25 at 2:00 p.m. The Immediate Jeopardy was removed, and the deficient practice corrected, on 4/16/25, prior to the start of the survey and was therefore Past Noncompliance. Findings include:	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

During an interview on 4/24/25 at 9:36 a.m., the Assistant Director of Nursing (ADON) indicated, on 4/15/25 at approximately 7:00 p.m., the ADON saw Resident B walking alone near a store approximately 100 yards from the facility. The ADON returned Resident B to the secured memory care unit.

During an interview on 4/24/25 at 10:58 a.m., the Social Service Director (SSD) indicated Resident B started exit seeking as soon as he was admitted to the facility. Resident B had packed his belongings and set them in the dining room on the secured unit several times in the days prior to Resident B climbing out of his window. Resident B told the staff that he believed "they" were trying to send him to a nursing home and would stand and knock on the back door, the front door, and the courtyard door. Resident B was adamant that he was going home.

During an interview on 4/24/25 at 11:31 a.m., RN 1 indicated she was the nurse for the secured memory care unit, on 4/15/25, when Resident B climbed out of his window but was not actually on the unit. There was a Qualified Medication Aide (QMA) that was working on that unit. RN 1 was not aware that Resident B exited the secured memory care unit until he had been brought back to the facility by the DON at approximately 7:30 p.m. that evening.

On 4/24/25 at 12:11 p.m., the windows in the room where Resident B exited the secure memory care unit was observed. There were two windows side by side, each approximately 30 inches wide by approximately 48 inches tall (upper and lower windows 24 inches tall each).

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F 689	Continued From page 3	F 689		

There were two window locks at the top of the lower window and a small tab at each side of the top of the lower window. There were screws in the window track to block the window from opening vertically and one screw into each of the tabs. There were silver L shaped brackets screwed into the upper and lower windows frames. Immediately outside the window, was an area of dirt and gravel that extended approximately 4 feet out from the window. Then a retaining wall approximately five feet tall dropped down to the parking lot. At that time, the windows were secured shut and the Administrator indicated the tabs on each side of the top of the bottom window can be pressed inward and the bottom window can be pulled inward and laid flat while still inside the frame. Resident B broke the left tab, with the screws in place, and laid the window flat. Then, Resident B climbed out of his window to exit the secured unit.

On 4/24/25 at 11:23 a.m., the ADON provided a copy of an incident timeline and indicated this was the timeline of events when Resident B exited the secured unit through his window. A review of the timeline, dated 4/15/25, indicated:

- At 5:49 p.m., Resident B finished his meal and spoke with QMA 1 about another cup of juice and stated he was going to go to bed as he said he was tired

- At 5:51 p.m., Resident B was observed by staff walking to his room.

- At 6:57 p.m., Resident B was observed outside the facility near a store, ambulating on the sidewalk and was immediately accompanied by staff and returned to the facility.

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F 689	Continued From page 4	F 689		

The clinical record for Resident B was reviewed, on 4/24/25 at 12:45 p.m. The diagnoses included, but were not limited to, dementia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and glaucoma-bilateral eyes.

A Hospital Discharge Summary, dated 4/10/25, indicated Resident B presented to the emergency department for an unknown reason and was being admitted due to concern for his safety on his own. In the emergency department, Resident B became much more agitated and expressed a desire to leave. However, Resident B was not able to provide hospital staff with a concrete plan for where he would go and how he would get there, which raised concern for Resident B's safety while on his own. Resident B lived alone, and family were concerned he was no longer able to care for himself. Resident B's family was actively pursuing guardianship.

An Admission Observation, dated 4/10/25, indicated Resident B was alert to self only.

An Elopement Risk Assessment, dated 4/10/25, indicated Resident B was able to move freely and easily which would allow the resident the capability of leaving the facility unassisted, often asked to go home or searched for home, exhibited significant cognitive impairment that impacted the elopement risk, was diagnosed with dementia, and was assigned a security bracelet. Resident B was at risk for an elopement.

Progress Notes included, but were not limited to:

- On 4/11/25 at 8:51 a.m., Resident B was exit

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F 689	Continued From page 5	F 689		

seeking.

-On 4/11/25 at 8:54 a.m., Resident B was in the hallway pushing on doors to go outside.

- On 4/15/25 at 9:46 a.m., writer observed Resident B in dining room, Resident B was still looking for an exit.

- On 4/15/25 at 11:52 a.m., Resident B was oriented to person, was alert, angry, and exit seeking. Resident B had been going door to door trying to leave. Resident B stated he needed out of here. When assisted to the courtyard, he became angry because he couldn't get out of the courtyard area.

- On 4/15/25 at 2:39 p.m., Resident B continued to insist that staff let him leave and stated he came to the facility to volunteer and didn't want to stay. Resident B was redirected but was short lived.

- On 4/15/25 at 7:49 p.m., spoke with Resident B following return to the facility. He remembered leaving the facility and planned to go home, but he wasn't sure where he was nor where he lived anymore.

- On 4/15/25 at 8:00 p.m., Resident B broke the window in his room and jumped out. The Assistant Director of Nursing found Resident B approximately 100 yards from the facility. Resident B still wanted to leave the facility.

An Event Note, dated 4/16/25 at 10:11 a.m., indicated on the previous evening Resident B had eaten dinner, other residents were watching television, and Resident B had asked for a juice

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F 689	Continued From page 6	F 689		

and shut his door. Resident B opened his window and jumped out. Resident B was redirected back to the building.

On 4/24/25 at 1:10 p.m., observed the path from the facility to the store where Resident B was found by the ADON. The store parking lot was approximately 100 yards from the facility with flat terrain and a sidewalk to the parking lot.

On 4/24/25 at 11:21 a.m., the ADON provided a copy of a facility policy, dated 10/2020, titled Elopement Prevention and Response Program, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility that staff who have residents under their care are responsible for knowing the location of those residents.

The past noncompliance Immediate Jeopardy began on 4/15/25. The Immediate Jeopardy was removed and the deficient practice corrected by 4/16/25 after the facility implemented a systemic plan that included the following actions: audits of elopement evaluations and care plans, inservicing staff on elopement procedures, and ongoing monitoring.

This citation relates to Complaint IN00457689.

3.1-45(a)(2)