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	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD GREENWOOD, IN 46143

(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 IN00444760. Complaint IN00444760 - State deficiencies related to the allegations are cited at R52. Survey date: October 17, 2024 Facility number: 014079 Residential Census: 74 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed October 22, 2024.	R 0000	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Director of Health and Wellness updated this resident's wandering assessment and service plan to reflect the recent elopement. Before staff take this resident off the unit, they are informing the nurse, signing the resident off the neighborhood, and staff member agrees to stay with the resident for the duration that she is out of the neighborhood. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Director of Health and Wellness or designee will complete Wandering Risk Assessments on current residents who have been identified as having exiting seeking behavior. Residents who have been identified as potential to elope due to exit seeking behaviors have interventions put into place in their service plan. We have updated these residents service plans to include interventions to be completed by 11/30/2024 **What measures will be put into place or what systemic**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julia Berry	Executive Director	11/13/2024

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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			changes the facility will make to ensure that the deficient practice does not recur Executive Director provided re-training of memory care staff, implementation of new forms, implemented a binder at the front desk to show a picture of any resident who is an elopement risk. Demaree's Director of Health and Wellness and Memory Care Director or designees are doing audits of 5 random current memory care residents a week for the next 3 months. Executive Directror provided retraining on Elopement to the current staff of memory care on Oct 10th. Executive Director developed a process for staff and families to sign any residents who live on memory care, in and out of the neighborhood and they will accept care of the resident while in their care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Binder at the front desk is updated weekly by the Director of Health and Wellness or designee. Demaree's Memory Care Director and Director of Health and Wellness or designees will review resident service plans monthly for three months to ensure that	

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			interventions that are in place for those residents identified who might be at risk for elopement. The Executive Director/designee will review monthly audits and make necessary corrective action immediately. Residents who are identified as a wandering risk are reviewed in weekly IDT meeting and service plan is updated as needed for changes. **By what date the systemic changes will be completed.** 11/30/2024	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview, and record review the facility failed to protect the resident's right to be free from neglect for 1 of 3 residents reviewed for elopement. This deficient practice resulted in a MCU (Memory Care Unit) resident exiting the facility without staff knowledge and wandering off facility property. The resident was escorted back to the facility until a visitor saw her off facility property. (Resident B) Findings include: During an interview on 10/17/24 at 8:09 a.m., the Administrator indicated, on 10/5/24 at approximately 2:00 p.m., Resident B was escorted activities staff from the MCU to a church service in the main lobby of the facility. The church service ended at approximately 3:00 p.m., and Resident B exited the facility unattended by staff and walked out the front door of the facility with	R 0052	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Director of Health and Wellness updated this resident's wandering assessment and service plan to reflect the recent elopement. Before staff take this resident off the unit, they are informing the nurse, signing the resident off the neighborhood, and staff member agrees to stay with the resident for the duration that she is out of the neighborhood. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	11/30/2024

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	visitors. Resident B was found standing in front of a house in the neighborhood next to the facility by a visitor. During a continuous observation, on 10/17/24 from 8:20 a.m. through 8:30 a.m., the main lobby was a large, open room located approximately 25 feet from the front exit of the facility. On 10/17/24 at 8:46 a.m., the Administrator provided a copy of an undated screenshot of an employee statement. The statement indicated Resident B was taken to an activity outside the MCU by the activity staff. The activity was over at approximately 3:00 p.m. A visitor saw Resident B walking, west, down the main road at approximately 3:15 p.m., so he stopped and picked up Resident B. QMA 1 saw Resident B and the visitor return to the MCU at approximately 3:20 p.m. The visitor told QMA 1 that Resident B said she had gotten lost on her way to church. During an interview on 10/17/24 at 9:42 a.m., Qualified Medication Aide (QMA) 1 indicated, on 10/5/24 at approximately 4:30 p.m., Resident B returned to the MCU with a visitor. During an interview on 10/17/24 at 9:48 a.m., Activity Assistant 1 indicated she was not aware Resident B was outside the facility until after her shift ended on 10/5/24 at approximately 4:30 p.m. The last time Activity Assistant 1 saw Resident B that day was at approximately 2:45 p.m. The clinical record for Resident B was reviewed on 10/17/24 at 10:03 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and osteoporosis. A Service Plan Assessment, dated 9/11/24,		**what corrective action will be taken?** Director of Health and Wellness or designee will complete Wandering Risk Assessments on current residents who have been identified as having exiting seeking behavior. Residents who have been identified as potential to elope due to exit seeking behaviors have interventions put into place in their service plan. We have updated these residents service plans to include interventions to be completed by 11/30/2024 **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** Executive Director provided re-training of memory care staff, implementation of new forms, implemented a binder at the front desk to show a picture of any resident who is an elopement risk. Demaree's Director of Health and Wellness and Memory Care Director or designees are doing audits of 5 random current memory care residents a week for the next 3 months. Executive Directror provided retraining on Elopement to the current staff of memory care on Oct 10th. Executive Director developed a process for staff and families to sign any residents who live on memory care, in and out of the neighborhood and they will	

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	indicated Resident B expressed a desire to go home or felt lost. A Service Plan, dated 9/13/24, indicated Resident B had moderate dementia with significant short term memory loss and required frequent safety checks. A Wander Risk Assessment, dated 9/28/24, indicated Resident B had a history of wandering. Resident B was at a moderate risk for wandering. On 10/17/24 from 10:15 a.m. until 10:20 a.m., the location where the visitor found Resident B was observed. Resident B was located standing in front of the first house entering the residential neighborhood approximately 0.1 miles from the facility. A sidewalk along the main road led back to the facility parking lot approximately 50 yards from the front door of the facility. On 10/17/24 at 8:46 a.m., the Administrator provided a facility policy, titled Elopement Response - Simulated and Actual, dated 3/22/24, and indicated this was the current policy used by the facility. A review of the policy indicated an elopement was an event in which an unassisted resident crossed any threshold of which they were categorized as being unable to leave unassisted. An example was a resident who resided on the memory care unit who existed without accompaniment. This citation relates to Complaint IN00444760.		accept care of the resident while in their care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** Binder at the front desk is updated weekly by the Director of Health and Wellness or designee. Demaree's Memory Care Director and Director of Health and Wellness or designees will review resident service plans monthly for three months to ensure that interventions that are in place for those residents identified who might be at risk for elopement. The Executive Director/designee will review monthly audits and make necessary corrective action immediately. Residents who are identified as a wandering risk are reviewed in weekly IDT meeting and service plan is updated as needed for changes. **By what date the systemic changes will be completed.** 11/30/2024	