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	10/03/2024

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00443577. Complaint IN00443577 - State deficiencies related to the allegations are cited at R0052. Survey date: October 3, 2024 Facility number: 013409 Residential Census: 35 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed October 7, 2024.	R 0000		
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. A resident with an assessed behavior of wandering and exit seeking was not provided the supervision to prevent the elopement which resulted in the resident exiting the facility and wandering over 0.7 miles from the facility. (Resident B) Findings include: On 10/3/24 at 10:42 a.m., Resident B was observed to be sitting in the day room doing exercises with activities. The exit side doors glass were observed to be painted.	R 0052	PLAN OF CORRECTION FOR STONECROFTHEALTH 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	10/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Black	Area Executive Director	10/18/2024

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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	On 10/3/24 at 11:09 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and right knee fracture. The Admission Legacy Evaluation and Service Plan, dated 8/26/24 at 9:19 a.m., indicated the following: - Resident B required physical assistance of a one person to push the wheelchair, staff should use a gait belt to steady during ambulation or provide some type of physical assistance. The mobility service plan was to provide escort and/or supervision as needed, encourage safety precautions, and provide a wheelchair. - Resident B was an elopement risk because of the history of exit seeking behaviors, voiced statements of leaving, exhibited periods of pacing, agitation or wandering toward an exit, and had a history of elopement. The elopement service plan was to be on a secured unit (Legacy) and to observe elopement attempts. A progress note, dated 8/29/24 at 11:40 a.m., indicated the medical doctor had indicated Resident B had dementia, nursing reported wandering and exit seeking behaviors, and Resident B lived on a locked memory care unit for their safety. A progress note, dated 9/14/24 at 5:42 p.m., indicated Resident B was going to all the exit doors and was trying to get out. She was cussing and throwing things. Her son was called so she could talk to him and she threw the phone. She was administered an emergency dose of Ativan (antianxiety medication).		conducted October 3rd, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of October 18th, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Tag R052 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - Resident B was immediately assisted back to the building and assessed with no injury or psychosocial issues noted. - Like residents were assessed with no findings. 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 like residents have the potential to be affected by the alleged deficient practice. - Education was provided to staff by the DHS/ADHS. Education provided: Guideline for Elopement/Missing Resident 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As a measure of ongoing compliance, the Director of Plant	

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	The Exit Seeking Event Report, dated 9/17/24 at 7:53 p.m., indicated Resident B was exit seeking and wandered off the property. She had no wandering alert device on. Prior to exit seeking, she had verbalized statements about leaving and said she wanted to go home. She had cognitive impairment that affects her safety and judgement. She was mad at her son for not taking her home. A progress note, dated 9/18/24 at 11:00 a.m., indicated Resident B had pushed the exit door to the outside until it unlocked. She then proceeded to exit through the door outside of the campus. She was located and returned to the campus. The timeline provided by the DON on 10/3/24 at 11:10 a.m., from the facility investigation into Resident B's elopement, dated 9/17/24, indicated the following: - At 5:00 p.m., Resident B was eating dinner at the table. - At 5:15 p.m., Resident B remained at the dinner table. - At 5:18 p.m., Resident B pushed the Legacy (secured memory care unit) unit door on the west side of the building until it unlocked. She exited the door to the outside. - At 5:21 p.m., CNA 1 exited through the same door and began searching for Resident B (3 minutes after Resident B exited the door). - At 5:25 p.m., CNA 2 was observed to shut off the alarm and began searching for Resident B (7 minutes after Resident B exited the door). - At 5:40 p.m., Resident B was located 0.7 miles		Operations or designee will conduct elopement drills weekly x 4 weeks and then every other week x 2 months than monthly x 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: 10/18/2024	

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	from the facility in a church parking lot by DPO (Director of Plant Operations). She was returned from the facility (22 minutes after Resident B exited the door). The Exit Seeking Event Report, dated 9/21/24 at 3:30 p.m., indicated Resident B was exit seeking. Prior to exit seeking, she was angry about facility placement and was packing her belongings. She had cognitive impairment that affects her safety and judgement. She was mad at her son for not taking her home. A progress note, dated 9/21/24 at 3:31 p.m., indicated Resident B had an exit seeking event. She pressed open the doors and was walking on the sidewalk. She was redirected back to the unit. She was going home and had a bag in hand. During an interview on 10/3/24 at 12:24 p.m., Registered Nurse (RN) 1 indicated she had worked 6:00 a.m. through 6:00 p.m. on 9/17/24 on 200 hall. Around 5:25 p.m., the 300 rehabilitation unit hall nurse called to tell her Resident B had eloped. She started looking for Resident B outside. She walked around the sidewalk and went towards the highway to Ivy Technology (Ivy Tech), a school. The exit doors would open when it was pressed for 15 seconds. During an interview on 10/3/24 at 12:30 p.m., RN 2 indicated she had worked 6:00 a.m. through 6:00 p.m. on 9/17/24 on 300 rehabilitation unit hall. She was alerted by CNA 1 that Resident B was missing. She went on the Legacy Unit to a do a room sweep and could not find Resident B. She called RN 1 on 200 hall to initiate the process of finding a missing resident and she started looking around outside.			

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	During an interview on 10/3/24 at 12:40 p.m., Qualified Medication Aide (QMA) 1 indicated when Resident B was first admitted, she would say she wanted to go home and her son was going to pick her up. She would say she was leaving and pack her things. In the evenings from 2:00 p.m. - 6:00 p.m., she would attempt to open the doors and attempt to leave facility. During an interview on 10/3/24 at 1:30 p.m., the Director of Plant Operations (DPO) indicated on 9/17/24 around 5:30 p.m., he was getting ready to leave work for the day when CNA 2 indicated they could not find Resident B. He got in his car and drove around the facility and took the highway toward Ivy Tech and did not see Resident B. He proceeded to turn around and went back towards the facility and went to the other stoplight. He went through the subdivision to the facility and did not see Resident B. He then went back towards Ivy Tech and at the next stoplight saw Resident B walking on the sidewalk. Around 5:40 p.m., he picked Resident B up in a church parking lot and brought her back to the facility. Resident B was approximately 0.7 miles from the facility. Resident B indicated she was trying to go home. Once he got Resident B back to the facility, he checked the security camera. He observed Resident B press on the door until it opened. After a minute, CNA 1 looked outside and then looked in rooms and then down the hall to rehabilitation unit to alert other staff. During an interview on 10/3/24 at 1:34 p.m., CNA 1 indicated she had worked on 9/17/24 from 6:00 a.m. through 6:00 p.m. During the shift, Resident B was frustrated and wanted to leave. She had pushed the door earlier and was trying to leave the facility. When she was exit seeking, they would try to get her to watch television or read			

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	books. The interventions were not working. She was still trying to leave the facility. Around 5:30 p.m., the Legacy Coordinator left the unit because she had a meeting. She was on the unit by herself. Resident B was sitting at the dining room table, when another resident needed to go to the bathroom. While in the resident's bathroom, CNA 1 heard the door alarm sounding. She immediately went running to the door to check out the alarm. While running, she was calling out Resident B's name and she was not answering. The door was locked and she could not open it. She went to 300 rehabilitation hall to alert the nurse Resident B was missing. During an interview on 10/3/24 at 1:56 p.m., CNA 2 indicated she had worked on 9/17/24 from 6:00 a.m. through 6 p.m. on the 300 rehabilitation hall. Around 5:15 p.m. to 5:20 p.m., she heard an "emergency" light. She was trying to find where the light was going off when, CNA 1 came out of the Legacy unit and told her she couldn't find Resident B and could not shut the alarm off. She turned off the alarm, did a headcount and checked each room, and went outside. She could not find Resident B and she went back in the facility to tell RN 2. CNA 2 returned outside to look for Resident B. CNA 2 indicated the alarm sounded for 2 two minutes before she began checking outside for Resident B. During an interview on 10/3/24 at 3:20 p.m., the DPO indicated CNA's could not open the exit doors with their badges, but could open the doors by pressing for 15 seconds until they opened. On 10/3/24 at 3:15 p.m., the Director of Health Services (DHS) provided the policy, "Guideline for Elopement/Missing Resident," dated 12/31/23, and indicated it was the policy currently being			

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	used by the facility. A review of the policy indicated, "...a. Staff should respond promptly to a sounding door alarm...ii. Two additional staff members to exit the alarming doorway and go in opposite directions around the building perimeter until they meet each other and return to the central area of the facility.." This citation relates to Complaint IN00443577.			