STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING _____ B. WING _____	C 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00448365. Complaint IN00448365 - Federal/State deficiency related to the allegations is cited at F689. Survey date: December 3, 2024 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 8 Medicaid: 57 Other: 19 Total: 84 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 10, 2024.	F 000		
F 689 SS=D	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.	F 689		

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

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow procedures, adequately supervise, and ensure a resident's safety while on an outing related to a resident falling and rolling into a lake (Resident B) for 1 of 3 residents reviewed for accident hazards. Findings include: During a telephone interview on 12/03/24 at 11:39 A.M., Certified Nurse Aide (CNA) 3 indicated she worked in the Activities Department and she and Bus Driver (BD) 4 took seven residents from the Memory Care Unit on the facility bus for an outing in October. They drove to a local donut shop and then went to a local lake/park area. They arrived at the lake, got the residents off the bus, and sat them down at some picnic tables. There were residents that were in wheelchairs and residents that were able to walk without assistive devices. While the other residents were sitting at the tables, CNA 3 and BD 4 were walking with Resident B near the water, about 10 feet away from the residents at the table. CNA 3 asked BD 4 to watch Resident B while she walked back towards the other residents. A couple minutes later, BD 4 yelled "Help!" CNA 3 looked back and saw Resident B in the lake sitting in the water. CNA 3 jumped into the lake. The water was only a couple of feet deep. CNA 3 eased Resident B towards the shore but she couldn't get him out of the water, so she stayed in with him. Someone called 911 and the police and an ambulance came to the park. CNA 3 and a police officer were able to get the resident out of the water. They wrapped a blanket around the resident. The resident refused to go in the ambulance but was	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

assessed by the Emergency Medical Technician (EMT) and was not injured. CNA 3 called the facility and the EMT spoke with Resident B's nurse. CNA 3 was told to bring the residents back, so they loaded everyone up and went back to the facility. CNA 3 indicated she thought BD 4 would watch the resident. CNA 3 turned her back on the resident at the time of him entering the lake.

During an interview on 12/03/24 at 11:51 A.M., the Director of Nursing (DON) indicated she was not sure how the incident occurred, and she was not at the facility when it happened. They were just supposed to just go on a bus trip to the bakery and get donuts and take a drive around the lake. She thought BD 4 and CNA 3 took it upon themselves to decide to stop and get the residents off the bus. CNA 3 received disciplinary action for the incident.

During a telephone interview on 12/03/24 at 11:59 A.M., CNA 3 indicated before they left for the outing, she told the Memory Care Unit Coordinator she was going to take the residents off the bus. The Unit Coordinator said "okay" and if she had any problems give her a call. CNA 3 realized after talking with the DON that she shouldn't have had that many residents on the outing. She was thankful that Resident B was okay.

During an interview on 12/03/24 at 11:11 A.M., RN 2 indicated Resident B exhibited a lot of behaviors. The resident had been physically and verbally aggressive, and in the past had cursed and slapped at staff and refused care. The resident had recently declined and was using a wheelchair now, but back in October he was up

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walking without any assistive devices. He wandered a lot; He used to do laps around the unit but was really unsteady.

The clinical record for Resident B was reviewed on 12/03/24 at 12:30 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/23/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, non-Alzheimer's dementia and anxiety.

During an interview on 12/03/24 at 1:09 P.M., the Administrator indicated CNA 3 and BD 4 were just supposed to take the residents on a bus ride. They were instructed to contact the Memory Care Unit Coordinator if the stopped anywhere. They did not call the Memory Care Unit Coordinator when they stopped the bus at the park/lake.

A document, titled "Employee Communication Form" was provided by the Administrator on 12/03/24 at 1:13 P.M. The form indicated CNA 3 violated the Activity Outing Policy on 10/08/24 when she was instructed not to take the residents off the bus unless she contacted the Memory Care Unit Coordinator first so that the Unit Coordinator could drive to the location to be present for supervision. The bus stopped at a local lake and there was an occurrence with a resident falling and rolling into the lake. The employee not only put that resident in a situation where there was inadequate supervision and assistance, but the other six residents that were on the outing as well.

An undated document signed by BD 4 was provided by the Administrator on 12/03/24 at 1:40 P.M. The document indicated BD 4 was walking

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with Resident B on an outing at the lake. She turned away from the resident and looked towards CNA 3 to be sure the CNA was with the other residents. BD 4 turned back around to walk with Resident B and realized the resident was getting ready to fall. The resident fell to the ground and started rolling towards the water. BD 4 ran towards him, and they both got to the edge of the shallow water. BD 4 called out for help while she held on to the resident so he wouldn't panic. With help, they got the resident's hips out of the water and onto the bank of the lake and called 911. The police and an ambulance came. An EMT assessed the resident and said he looked okay. She got a wheelchair off the bus, assisted the resident into the wheelchair, and covered him with a blanket. They loaded all the residents onto the bus and returned to the facility.

The current, undated facility policy, titled "Outing Checklist" was provided by the Administrator on 12/03/24 at 1:13 P.M. The policy indicated, "...Supervision always required on an outing...No resident should be left unattended..."

The current facility policy, titled "Activity Outing Policy", dated 07/15, was provided by the Administrator on 12/03/24 at 1:13 P.M. The policy indicated, "...it is the policy...to offer both enjoyment and safety during outings coordinated by the facility...Residents will be supervised during the outing at all times..."

The Past noncompliance began on 10/8/24. The deficient practice was corrected by 10/11/24 after the facility implemented a systemic plan that included the following actions: IDT members met on 10/9/24 and implemented new care plan intervention for resident to ambulate with one

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F 689	Continued From page 5 assist when outdoors. MD/Responsible Party/ED/DNS were notified of incident; Outing Checklist created by Executive Director; and Activity Department, Memory Care Activity Department and IDT in-serviced on the Activity Outing Policy and Outing Checklist on 10/11/24. This citation relates to Complaint IN00448365. 3.1-45(a)(2)	F 689		