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	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SANDERS GLEN	334 S CHERRY ST WESTFIELD, IN 46074

(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 a State Residential Licensure Survey. Survey dates: April 30 and May 1, 2024 Facility number: 005657 Residential Census: 99 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 8, 2024.	R 0000	This plan of correction constitutes Sanders Glen's written allegation of compliance for the deficiencies cited in the annual survey conducted April 30, 2024 and May 1, 2024. Submission of this Plan of Correction does not constitute an admission that a deficiency exists or was cited correctly. This Plan of Correction is being submitted to meet state and federal requirements. Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements.	
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. Based on observation, interview and record review, the facility failed to protect a resident with a diagnosis of dementia from neglect when the resident exited the building without staff knowledge, during the night shift, for 1 of 1 resident reviewed for neglect and elopement. (Resident 6) Finding includes: A Facility Reported Incident (FRI), dated 12/25/23,	R 0052	*Corrective action for identified resident:* Affected resident, based on specific change of condition, has been discharged to a facility with a higher level of acuity. *Identification and corrective action for other residents with the potential to be affected:* All residents have the potential to be affected. A review of all	05/17/2024

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

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	indicated Resident 6 was discovered outside of the building at an adjacent house to the facility property. During an observation, on 5/1/24 at 11:45 a.m., the path to Cherry Street was found to be paved and smooth. The house Resident 6 went to was located on the same side of the road as the facility and 0.2 miles away. At the time of the observation, the road was found to be lightly traveled by motor vehicles. The clinical record for Resident 6 was reviewed on 5/1/24 at 11:30 a.m. The diagnoses included, but were not limited to, osteoarthritis, hypertension, and Alzheimer's dementia. A nursing note, dated 6/21/23 at 9:04 a.m., indicated Resident 6 was found outside wearing a coat, at 6:50 a.m., after the door alarm had sounded. The resident indicated she was waiting for her son to take her to a family reunion. She was returned to the inside of the building. A nursing note, dated 12/25/23 at 3:10 a.m., indicated Resident 6 was found outside of the facility, at 2:00 a.m., by a neighbor. The resident was returned to the facility. She was dressed in warm clothing and wearing shoes. She was assessed with no findings and denied pain, discomfort, and feeling cold. A facility report indicated, on 12/25/23 at 1:15 a.m., a neighbor reported to Resident 6's son his mother had arrived at their house at approximately 1:15 a.m. At 1:50 a.m., the local police arrived at the facility with a photo of Resident 6. The staff confirmed she was a resident of the facility. The neighbor then escorted Resident 6 back to the facility. Upon her return, she indicated she was		resident records for a history or ideation of wandering or exit seeking has been conducted. No additional residents at risk for wandering or exit seeking behaviors were identified. This facility maintains alarmed doors as a layer of security. Doors and door alarms were all determined to be in working order. *Measures to prevent recurrence:* Education provided to all care staff, specifically to identifying early signs of change in condition for residents. All staff educated to notify Administrator, Director of Nursing or designee, of any resident with a cognitive impairment exiting the building alone, at an inappropriate time of day or displaying poor judgement. A level of care assessment and a cognitive assessment will be initiated for any resident displaying a change in condition, coupled with wandering and/or exit seeking behavior. Residents assessing with a Severe Cognitive Impairment may necessitate additional safety interventions or necessitate a discharge. Education provided to all residents during the May 20, 2024 Resident Meeting, requesting residents to refrain from assisting other residents to the outside when circumstances seem unusual. Request made to residents to notify staff for assistance regarding any unusual	

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	going to LaPorte to see her family. A facility statement, dated 12/25/23, signed by CNA 1 indicated the CNA reported to the QMA she had encountered Resident 8 looking out the door. Resident 8 told the CNA "she can just stay with me". CNA 1 spoke with Resident 8 but was not able to get specific information from the resident. She contacted the QMA on duty and they searched outside the building but did not find anyone outside. She then notified the Director of Nursing and staff began a search of the facility rooms. Around 1:50 a.m., the local police arrived at the facility with a picture of Resident 6 and CNA 1 identified the resident. Resident 6 was returned to the facility. She did ask Resident 6 where she was going, and the resident told her she was going to LaPorte to see her family. During an interview, on 5/1/24 at 9:53 a.m., the Executive Director indicated on the night Resident 6 exited the building (12/25/23), another resident was found at the doors, looking out. A CNA making rounds observed the resident looking out the door. The resident said something like "she did not have to leave she could stay with me." The resident returned to her apartment and staff did observe the outside of the building but did not find anything. The police came to the facility with a picture of Resident 6 and inquired if she resided at the facility. Facility staff indicated she was a resident. A neighbor returned the resident to the facility. The Executive Director indicated the resident did leave the premises and went to the first house on Cherry Street. She followed the trail, no one was aware she had exited the facility. During an interview, on 5/1/24 at 11:33 a.m., the Director of Nursing indicated the facility did not		circumstance, such as another resident wishing to exit who seems confused or at an inappropriate time. Prospective residents who assess at risk for wandering, will not be admitted to this facility. *How will the facility monitor and who is responsible:* Director of Nursing or designee will review all regulatory required resident assessments on a monthly basis. Resident assessments triggered by a change in condition will be reviewed within a 24 hour period for determination of necessary interventions and/or discharge. Residents identified with a change of condition and a cognitive impairment, who do not necessitate an immediate discharge, will be reviewed during the facility's monthly Quality Assurance Program for any additional recommendations or interventions.	

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	do elopement assessments. During an interview, on 5/1/24 at 11:35 a.m., the Executive Director indicated it was believed Resident 8 may have assisted Resident 6 to get out of the door, the door was locked with a coded keypad. A facility policy, titled "Residential Care Policies and Procedures," dated as issued on 3/4/19 and received from the Director of Nursing on 5/1/24 at 11:54 a.m., indicated "...Residents have the right to be free from...neglect...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure food on the lunch line was maintained at an appropriate temperature for 1 of 1 steam table observed for food temperatures. Finding includes: During an observation of food temperatures, on 4/30/24 at 12:54 p.m., the following foods were found in the steam table, uncovered, and held below the appropriate temperature: 1. The cooked carrots were found to be at 116. 7 degrees. 2. The mixed vegetables were found to be at 118.4 degrees. 3. The polish sausage was found to be at 118.9 degrees.	R 0273	*Corrective action for identified resident and identification and corrective action for other residents with the potential to be affected:* No specific resident was identified. All residents have the potential to be affected. Administrator and Food Service Director reviewed practices and logs to identify any breakdowns in procedures. Systemic changes have been implemented to ensure compliance with safe food handling standards. *Measures to prevent recurrence:* Administrator and Food Service Director revised daily hot food temperature log to include an	05/17/2024

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	4. The chicken breasts were found to be at 120.4 degrees. During an interview, on 4/30/24 at 12:58 p.m., the Kitchen Manager indicated hot food should be held at 141 degrees Fahrenheit and they should have been covered with a lid. A facility policy, titled "Dietary Policies and Procedures," dated as issued 07/07 and received from the Director of Nursing on 5/1/24 at 11:54 a.m., indicated "...All hot food items must be served at a temperature of at least 135 (degrees) F (Fahrenheit)...."		additional round of temperature monitoring. New hinged lids have been purchased to ensure food remains covered and retains heat. Education provided to Food Service staff regarding new procedures and the proper holding temperatures for both hot and cold food products. Education also made regarding the proper temperature to maintain the steamtable unit to ensure hot food holds at the proper temperature. *How will the facility monitor and who is responsible:* Food Service Director or Designee will review food temperature logs to ensure compliance. Food Service Director of Designee will conduct random temperature checks on both hot and cold food to ensure compliance. Copies of temperature logs will be submitted to the Administrator for a period of six weeks to ensure compliance. Discrepancy of practice will be reported on a monthly basis through the facility Quality Assurance process.	