	NTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/25/2022		
	PROVIDER OR SUPPLIE	R	27	REET ADDRESS, CITY, STATE, ZII 70 S ADAMS RD OOMINGTON, IN 47403	P CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
R 0000							
Bldg. 00	IN00380504. Complaint IN0038 deficiencies related	he Investigation of Complaint 0504- Substantiated. State I to the allegations are cited at	R 0000				
	R0052. Survey date: May Facility number: 00 Residential Census	04016					
	accordance with 41	tial Finding is cited in 0 IAC 16.2-5. npleted May 27, 2022.					
R 0052 Bldg. 00	 (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punis; (5) neglect; and (6) involuntary se Based on interview facility neglected to impaired residents without staff know reviewed. (Residents) 	- Offense re the right to be free from: e; hment; clusion. r and record review, the p prevent a cognitively from exiting the facility ledge for 1 of 3 residents	R 0052	R052 Resident's Rig 1. What corrective a be accomplished for residents found to ha affected by the defici Resident B was eval nursing on 5/17/22 to injury had occurred.	action(s) will those ave been tent practice: uated by o ensure no	06/23/2022	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	R MEDICARE & MEDI				OMB NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		05/25/2022
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				S ADAMS RD	
MONRC	DE PLACE		BLOO	MINGTON, IN 47403	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ed. The clinical record		during the assessment. Reside	
	-	nission a wanderguard was		B was immediately placed on 1	1:1
		ent B for intermittent		supervision upon returning to	
		story of standing near the		community, Executive Director	
	doorway for an op	portunity to leave.		and Care Services Manager	
				notified family on 5/17/2022 to	
	-	s included, but were not		discuss immediate alternative,	
	limited to:			safe living options for resident.	
 4/30/22, The door alarm sounded, Resident B was observed to be walking east on the sidewalk and was redirected back to the community. 5/8/22, Resident B was found outside on the sidewalk after the alarm sounded. Resident B was redirected back to the facility. The note indicated the facility called the family and indicated the family would need to provide one 			Resident B was transferred to	а	
			Memory Care Community on		
			5/17/2022.		
		back to the community.			
			2. How the facility will identify		
			other residents having the potential to be affected by the		
			same deficient practice and wh	at	
			corrective action will be taken:	iat	
	on one supervision of Resident B. Resident B's			Elopement drill was performed	on
	family was agreea			each shift on 5/17/22 [Attachm	
	, ,			1-3] and Elopement Risk and	
	A Mini Mental Sta	tus Exam, dated 5/2/22,		Policy and Education reviewed	
	indicated Resident	B had cognitive impairments.		with all staff members.	
				[Attachment 4]	
	An Elopement Ris	k Assessment, dated 5/2/22,		Between 5/17/22-5/20/22, Care	e
	indicated Resident	B was a high risk for		Services Manager conducted	
	elopement.			elopement assessment of curr	
				residents to ensure appropriate	
		0 P.M., the Executive		interventions in place to reduce	9
		a reportable incident from		risk of elopement and provide	
		icated that Resident B had		documentation for team memb	
		nity without staff knowledge		to be aware of residents at risk	for
		ided. Resident B was located		elopement. [Attachment 5]	
	e e	neighborhood (approximately			
		e facility) and was redirected		3. What measure will be put int	
		nity. Resident B was not		place or what systemic change	
	injured.			the facility will make to ensure	Inat
	0	DM the Energiation D'		the deficient practice does not	
		P.M., the Executive Director		reoccur:	
	and wenness Dire	ctor indicated the facility had			

TAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCE TO THE APPROPRIATE DIFFICUENCYDATEcommunication with Resident B's family regarding her elopements. Resident B wore a wanderguard which was routinely checked for function. The Executive Director indicated the exit doors alarm to an electronic device staff carried. The Executive Director further would talk, however, if the staff were somewhere else in the facility they may not get to the door quick enough to prevent a resident from exiting the facility with a wanderguard mechanism was the front door. Since Resident B was eloping and the family agreed to provide 24 hours one on en supervision Resident B's family was advised other placement would be needed.TAGCROSS-REFERENCED TO THE APPROPRIATE DIFERENCE TO THE APPROPRIATE DIFERENCE TO THE APPROPRIATE DEPRETENCE TO THE APPROPRIATE DEPRETENCE TO THE APPROPRIATE DIFERENCE TO THE APPROPRIATION DIFERENCE TO THE APPROPRIATION DIFERE	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391				
NAME OF PROVIDER OR SUPPLER 2770 S ADAMS RD BLOOMINGTON, IN 47403 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY DETAIL TAG COMPLET DATE	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		A. BU	A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED		
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The Executive Director and Care Services Manager are responsible for compliance. The Care Services Manager and/or designee will audit 5 cognitively impaired resident records weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure appropriate risk interventions in place to maintain	(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN REGULATORY OF communication with regarding her elope wanderguard which function. The Execu- indicated the exit d would talk, howeve else in the facility t quick enough to pro- the facility. The Ex- the only door in the mechanism was the was eloping and the hours one on one su- maintain the superv advised other place On 5/25/22 at 12:20 Director provided t Missing Resident" it was the facility p effort of all staff to resident was report	ACY MUST BE PRECEDED BY FULL RESCIDENTIFYING INFORMATION) th Resident B's family ments. Resident B wore a a was routinely checked for cutive Director indicated the an electronic device staff trive Director further oors had a stopper which er, if the staff were somewhere hey may not get to the door event a resident from exiting kecutive Director indicated e facility with a wanderguard e front door. Since Resident B e family agreed to provide 24 upervision but was unable to vision Resident B's family was ment would be needed. 6 P.M., the Executive he current "Elopement or policy, dated 3/1/22, indicated olicy to provide a systemic search for a resident when a ed missing.		ID PREFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) The Executive Director and C Services Manager were re-educated on 5/17/2022 by Regional Director of Care Services on Resident Rights, Abuse, Neglect, and Elopemer Policy and Procedure. [Attachment 6] The Executive Director and Care Services Manager reeducated current so on signs of Elopement Risk, Elopement Risk Assessment Elopement Risk Assessment Elopement Policy on 5/17/22, 5/18/22, 5/19/22 and 5/20/22. [Attachment 7] Care service Manager and/or designee will update resident Elopement Ri Assessments every 90 days of change of condition. The upda elopement risk assessment af and any change to resident risk will be discussed at the month meetings. 4. How the corrective action (st be monitored to ensure the deficient practice will not recut i.e., what quality assurance program will be put into place The Executive Director and C Services Manager are respont for compliance. The Care Services Manager and/or designee will audit 5 cognitive impaired resident records were for four weeks, biweekly for for weeks, then monthly for one month to ensure appropriate the month to ensure appropriate the context and the process of the service appropriate the month to ensure appropriate the month to ensure appropriate the context and the process of the service appropriate the month to ensure appropriate the month to ensure appropriate the month to ensure appropriate the montext and the process of the service appropriate the montext appropriate the monthy for one montext appropriate the monthy for one montext appropriate the montext appropriate the monthy for one montext appropriate the montext approprintext approp	Fare the ent staff and isk or at ated udits sks nly QI s) will ir, : : are isible	COMPLETION		

 Event ID:
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 If continuation sheet
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ſ					resident safety and prevent ris	sk of		
					elopement Results will be			
					reviewed monthly during QI			
					meeting. The QI committee w	ill		
					determine if continued auditin	g is		
					necessary based on 3			
					consecutive months of			
					compliance. Monitoring will be	e		
					ongoing.			
					Completion Date: 6/23/2022			

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Event ID: NKE911 Facility ID: 004016 If continuation sheet Page 4 of 4