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	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE PLACE	2770 S ADAMS RD BLOOMINGTON, IN 47403

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00380504. Complaint IN00380504- Substantiated. State deficiencies related to the allegations are cited at R0052. Survey date: May 25, 2022 Facility number: 004016 Residential Census: 49 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed May 27, 2022.	R 0000		
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 interview and record review, the facility neglected to prevent a cognitively impaired residents from exiting the facility without staff knowledge for 1 of 3 residents reviewed. (Resident B) Finding includes: On 5/25/22 at 11:45 A.M., Resident B's clinical	R 0052	R052 Resident's Rights – Offense 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B was evaluated by nursing on 5/17/22 to ensure no injury had occurred. No findings	06/23/2022

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

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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	record was reviewed. The clinical record indicated upon admission a wanderguard was placed upon Resident B for intermittent confusion and a history of standing near the doorway for an opportunity to leave. The Progress Notes included, but were not limited to: 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 on one supervision of Resident B. Resident B's family was agreeable. A Mini Mental Status Exam, dated 5/2/22, indicated Resident B had cognitive impairments. An Elopement Risk Assessment, dated 5/2/22, indicated Resident B was a high risk for elopement. On 5/25/22 at 12:20 P.M., the Executive Director provided a reportable incident from 5/17/22 which indicated that Resident B had exited the community without staff knowledge and the alarm sounded. Resident B was located walking in a local neighborhood (approximately one block from the facility) and was redirected back to the community. Resident B was not injured. On 5/25/22 at 1:21 P.M., the Executive Director and Wellness Director indicated the facility had		during the assessment. Resident B was immediately placed on 1:1 supervision upon returning to community, Executive Director and Care Services Manager notified family on 5/17/2022 to discuss immediate alternative, safe living options for resident. Resident B was transferred to a Memory Care Community on 5/17/2022. 2. 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: Elopement drill was performed on each shift on 5/17/22 [Attachment 1-3] and Elopement Risk and Policy and Education reviewed with all staff members. [Attachment 4] Between 5/17/22-5/20/22, Care Services Manager conducted elopement assessment of current residents to ensure appropriate interventions in place to reduce risk of elopement and provide documentation for team members to be aware of residents at risk for elopement. [Attachment 5] 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:	

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	communication 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 indicated the exit doors had a stopper which 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. The Executive Director indicated the only door in 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 one supervision but was unable to maintain the supervision Resident B's family was advised other placement would be needed. On 5/25/22 at 12:26 P.M., the Executive Director provided the current "Elopement or Missing Resident" policy, dated 3/1/22, indicated it was the facility policy to provide a systemic effort of all staff to search for a resident when a resident was reported missing. This State tag relates to Complaint IN00380504.		The Executive Director and Care Services Manager were re-educated on 5/17/2022 by the Regional Director of Care Services on Resident Rights, Abuse, Neglect, and Elopement Policy and Procedure. [Attachment 6] The Executive Director and Care Services Manager reeducated current staff on signs of Elopement Risk, Elopement Risk Assessment and 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 Risk Assessments every 90 days or at change of condition. The updated elopement risk assessment audits and any change to resident risks will be discussed at the monthly QI meetings. 4. 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: 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	

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			resident safety and prevent risk of elopement.. Results will be reviewed monthly during QI meeting. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. Completion Date: 6/23/2022	