STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00429296 and IN00432317. Complaint IN00429296: Fedral/State defeciencies related to the allegations are cited at F689. Complaint IN00432317: Federal/State deficiencies related to the allegations are cited at F689. Survey date: April 30 and May 1 & 2, 2024 Facility number: 000164 Provider number: 155263 AIM number: 100289550 Census bed type: SNF/NF: 31 Total: 31 Census payor type: Medicare: 1 Medicaid: 21 Other: 9 Total: 31 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on May 6, 2024.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective May 03 ,2024. This facility respectfully requests consideration for paper compliance from this Plan of Correction.	
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

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

Brandi Gladish 05/20/2024

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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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and a secured environment was in place to prevent a resident with dementia from exiting the facility and leaving the property. On 4/10/24, after being last seen by facility staff around 8:00 P.M., a resident exited the facility and was not realized to be missing until 8:45 P.M. when the resident was noticed to not be in her room. The resident was located by local law enforcement at 9:11 P.M. approximately 2.4 miles away at a residential residence along US Highway 50. (Resident C) This Immediate Jeopardy began on 4/10/24 when the facility failed to ensure Resident C did not exit the facility through a window in the front of the building, located in the dining room, and walked approximately 2.4 miles to a residential residence. Local law enforcement located the resident. The resident was treated at a local hospital for a facial laceration and minor head injury from multiple falls in a ditch before returning to the facility. The facility administrator was notified of the Immediate Jeopardy on 5/1/24 at 11:30 A.M. The immediate Jeopardy was removed on 5/2/24 at 3:50 P.M., but noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: Interview on 4/30/24 at 11:20 A.M., LPN 4 indicated that Resident C was at risk for	F 0689	1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. The resident was returned safely to the building at 12:15am on 4/11/2024. Resident was placed on 1:1 for 72 hours. All residents' windows were assessed to make sure stoppers were in place. Stoppers were added to the front living room and dining room area on 4/12/2024. b. Activity room stoppers were added 5/1/2024. c. An all-staff in-service on Managing Elopement: Safe support for someone at risk for elopement was completed by 4/15/2024. d. All windows and exits were assessed and secured. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. A nursing advantage elopement assessment was completed on all residents with a diagnosis of dementia or cognitive impairment and completed by 4/17/2024. b. Elopement care plans were	05/03/2024

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	elopement, wears a WanderGaurd bracelet (a device that triggers door alarms and locks monitored doors to prevent the resident from leaving unattended) and had eloped from the facility on the night of 4/10/24 by climbing through a window. LPN 4 indicated that Resident C had previously attempted to exit the facility through the front doors while a delivery was being made. Observation on 4/30/24 at 11:25 A.M., Resident C was near the nurse's station walking without assistance. Review of facility reported incidents on 4/30/24 at 11:30 A.M., an IDOH (Indiana Department of Health) Reportable Incident form completed by the facility administrator, with an incident dated of 4/10/24 at 9:03 P.M., indicated that the DON (Director of Nursing) was notified at approximately 9:00 P.M., that staff could not locate Resident C. The reported incident included "Type of injury added... Bruising of face and arms." The DON immediately notified administrator that facility had called and could not find Resident C in the facility. Administrator immediately called building to see when the last time they had seen Resident C. Staff stated they had last seen the resident around 8:00 P.M. Administrator called local police department at 9:11 P.M. and while on the phone with the county sheriff department, the police department received a call regarding the resident's location at a house near the facility. A follow up, added 4/15/24, included that Resident C was transported to a local hospital around 9:31 P.M. after exiting the facility on 4/10/24. A sheriff deputy called the administrator and said that a 911 call had been received at 8:49 P.M. regarding a woman walking on US Highway 50. The local police came to the		updated to reflect the current outcome of elopement assessments. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. Residents that identify as an increased risk of elopement have an order to check lock placement/functioning bedroom window every shift for safety. Care plans have been updated. b. All windows have stoppers placed on them. c. Elopement drills will be conducted every month and/or as needed. d. An elopement/dementia in-service will be done quarterly and as needed for all staff. e. 30-minute safety checks added to residents that identify as an increased risk of elopement. Care plans have been updated. f. Any residents that are actively exit seeking will be placed on 15-minute checks for 24 hours and reevaluated for further observation needs. g. An audit will be completed weekly x4 weeks, monthly for 3 months, then quarterly for 2 quarters to ensure windows locks are functional and in place. h. An audit will be completed weekly x4 weeks, monthly for 3 months, then quarterly for 2	

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	facility around 10:15 P.M. to follow up with the incident and discovered that a dining room window was open enough for an adult to climb out of. Record review on 4/30/24 at 12:00 P.M., Resident C's diagnoses included, but were not limited to, Alzheimer's Disease, altered mental status, anorexia, insomnia, and dementia. A risk for elopement assessment completed on 3/6/24 indicated the resident was at risk for elopement. Resident C's most recent Quarterly MDS (Minimal Data Set) dated 3/8/24, indicated that the resident's cognition was severely impaired, that the resident wandered daily, required supervision for completing activities of daily living (ADL's), and was independent with mobility without the use of an assistive device. Resident C's physician orders included, but were not limited to, check placement and functioning of WanderGaurd to right ankle (started 10/19/22). A care plan for elopement risk, dated 3/11/24, included, but was not limited to, interventions to allow resident to roam safely throughout the facility and approach resident in a friendly manner. The plan of care did not include documentation to indicate interventions to provide adequate supervision to prevent elopements were implemented. A care plan for intrusive wandering throughout the building, dated 3/21/24 included, but was not limited to, interventions to redirect resident away from doors.		quarters to ensure elopement drills and in-services are completed. i. Nursing advantage elopement assessment will be completed on admission, quarterly, and significant changes. j. An audit will be completed weekly x4 weeks, monthly for 3 months, then quarterly for 2 quarters to ensure effectiveness of interventions related to exit seeking. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. A Quality Assurance Assessment Audit Tool will be completed by the Director of Nursing/Designee weekly x4 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

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	A care plan for impaired cognitive function/dementia or impaired thought process due to Alzheimer's, dementia, dated 2/6/24, included, but was not limited to, interventions to cue, orient, and supervise as needed. Resident C's nurse's notes included, but were not limited to, the following: 3/15/24 at 4:16 P.M. - After family left, resident is extra exit seeking and adamant about leaving and notably frustrated with her situation. Order received to increased Zoloft to 200 mg (milligrams) and monitor changes. 3/22/24 at 10:30 P.M. - Resident to start Xanax in the morning. Resident just going to her room. Resident becomes angry and argumentative with staff and has been hiding in the dark dining room. 3/3/1/24 at 1:09 A.M. - Resident has shown agitation and increased desire to leave facility this evening. Resident noted to be observing the front door and visitors leaving the facility. Staff redirected resident away from the front door and into the nursing station area. 4/1/24 at 1:14 P.M. - Resident continues to be agitated with increased desire to leave facility. Resident standing at the doors on West unit hall pushing on them with some belongings in her hand. Resident unreasonably anxious and suspicious. 4/6/24 at 8:15 P.M. - Resident pacing the lobby and stated that she needs to get out to give her granddad his medications. Attempted to redirect without success. Keeping close eye on resident due to her wanting to leave. 4/10/24 at 9:00 P.M. - The resident was observed in the front lobby at 8:00 P.M., staff went to the resident's room to administer medications at 8:45 P.M., the resident was not in the room, and staff could not locate the resident in the facility. 4/10/24 at 9:15 P.M. - Resident found off site by			

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	police officers. Resident found with possible head injury and lacerations on arms and face. Resident C's hospital ER (Emergency Room) MD (Medical Doctor) Exam Note, dated 4/10/24 at 10:07 P.M., included, "...[Resident C] brought in by ambulance with unspecified facial trauma. Patient apparently eloped from nursing home... and was later found 2 to 3 miles away from facility. She had dried blood on her face with lacerations over the nose. She had multiple skin tears on the left upper extremity and one on the right upper extremity. Patient has baseline dementia and at baseline is only typically oriented to person... She does not recall exactly what happened but states that she fell in a ditch multiple times..." Diagnosis included, minor head injury, facial laceration, and skin tears. During a review on 4/30/24 at 12:30 P.M., the facility's investigation of Resident C's elopement on 4/10/24 included the following: A timeline of events dated 4/11/24 and signed by the Facility Administrator included: 9:03 P.M. - DON called Administrator to notify that Resident C was missing from the facility. 9:07 P.M. - Administrator called facility to see when staff had last seen resident. 9:11 P.M. - Administrator called local police department to notify them of missing person. While on phone, a dispatch from local sheriff department just located an elderly woman approximately 2.4 miles from the facility. 9:31 P.M. - Administrator received a call from deputy sheriff department, and they indicated they had received multiple 911 calls regarding a woman appearing injured walking on highway 50. The police first call had come in at 8:49 P.M. A handwritten note by LPN 7, dated 4/10/24,			

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	included that at 8:45 P.M., staff went to Resident C's room to administer medications and resident was not in the room. Staff checked area by bird cage in front lobby where they last saw the resident around 8:00 P.M. After staff searched the building, the DON was contacted at 9:00 P.M. At 10:15 P.M., the police came to follow up on the incident and when looking around, an officer shined flashlight around dining room and one window was noted to be open enough for an adult to climb out of. Windows are only inches away from the ground. Interview on 4/30/24 at 1:50 P.M., the Facility Administrator indicated that Resident C was able to unlock the front dining room window and raise the window high enough to climb through. The front windows of the facility were old windows that had been painted, they often stuck when trying to open or would not stay open if able to lift them, and they were heavy. The windows locked and the window latches were at about eye level. Since Resident C's elopement on 4/10/24, window stops were installed by maintenance staff so that the windows only open enough to let air in, but not enough for someone to climb through. The other windows in resident areas had been replaced prior to Resident B's elopement and had factory window stops on them. Interview on 5/2/24 at 11:40 A.M., LPN 4 indicated that Resident C's dementia had recently seemed to worsen causing an increase in behaviors including packing her belongings more often, attempting to use the keypads to exterior doors, and refusing medications. LPN 4 indicated that medications such as Zoloft had been adjusted in March due to the change; however, no non-pharmaceutical interventions or additional staff/supervision had been added to help prevent			

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	the increased exit-seeking behaviors or prevent the elopement. Observation on 5/1/24 at 10:30 A.M., two large windows located in the activity room of the facility did not have window stops installed. The windows were able to be unlocked and opened fully allowing enough space for an adult to exit through the window. The windows were similar to the windows in front of the building that Resident C was able to open and exit through. On 4/30/24 at 2:15 P.M., the Facility Administrator supplied a facility policy titled, Wandering and Elopements, dated 3/2019. The policy included, "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents ... If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety ..." On 5/1/24 at 11:30 A.M., the DON supplied a facility policy, titled Dementia - Clinical Protocol, dated 11/2018. The policy included, "...Treatment/Management... 4. Direct care staff will support the resident in initiating and completing activities and tasks of daily living. a. Bathing, dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed..." On 5/1/24 at 2:45 P.M., the DON supplied a copy of a staff educational in-service titled, Safe Supports for Someone at Risk for Elopement, dated 2022. The in-service included, "...An elopement occurs when a person leaves the premises of a safe environment, such as the home, without the necessary supervision to do so...			

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	Environmental Interventions... Do frequent location checks... Regularly check that doors and gates are securely locked... Lock windows... Place locks either high or low on exit doors..." The Immediate Jeopardy, that began on 4/10/24, was removed on 5/2/24 when the facility in-serviced the staff on elopement prevention and ensured the unsecured windows were secured with window stops but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, the facility continues to monitor residents at risk for elopement, continued staff education and elopement drills. This citation relates to complaints IN00429296 and IN00432317. 3.1-45(a)(2)			