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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR CREEK OF LOGANSPORT	3901 HIGH STREET RD LOGANSPORT, IN 46947

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00455363. Complaint IN00455363 - State deficiencies related to the allegations are cited at R52. Survey dates: April 8 and 9, 2025 Facility number: 004441 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 17, 2025.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on interview and record review, the facility failed to ensure a resident was free from neglect, when a resident with a diagnosis of dementia, who was at moderate risk for elopement, wandered away from the facility for an undetermined amount of time for 1 of 3 residents reviewed for elopement. (Resident B) This deficient practice resulted in Resident B ambulating approximately 0.38 miles and across a busy two-lane road away from the facility without staff knowledge. Findings include: A facility reported incident (FRI) indicated, on 3/11/25 at 2:53 p.m., Resident B exited the kitchen door to the outside and walked to a salon	R 0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense 1. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice: Resident B moved out of the community to live with family on 3/27/25. 2. How the facility will identify other residents who may be affected by the same deficient practice, and what corrective	05/22/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Thompson	Operations Specialist	05/08/2025

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	neighboring the community. The resident was returned to the community by a salon customer. The resident was able to give her son's cell phone number to the salon customer. The clinical record for Resident B was reviewed on 4/9/25 at 12:32 p.m. The diagnoses included, but were not limited to, dementia, Alzheimer's disease, intermittent confusion, and hallucinations. A Mini-Mental State Examination (MMSE), dated 3/3/25, indicated Resident B was moderately cognitively impaired. An elopement risk assessment, dated 3/3/25, indicated Resident B was highly mobile and liked to walk. She had diagnoses of Alzheimer's disorder, dementia, intermittent confusion, and hallucinations. Resident B exhibited disorientation and intermittent confusion. A nursing progress note, dated 3/4/25 at 7:15 a.m., indicated the resident was in the hallway very confused, and indicated she was asked to pack and leave. The resident was assured she was welcomed, and they were all glad to get to know her. A nursing progress note, dated 3/4/25 at 11:30 p.m., indicated the resident was very confused about the time and place and was very anxious and restless. The resident brought a box of belongings, a purse, keys, and her dog to the front to leave. The staff redirected the resident back to her apartment. A nursing progress note, dated 3/5/25 at 12:30 a.m., indicated the staff completed a safety check around the building and located Resident B		action will be taken: The Elopement Risk Policy and related education were reviewed with all staff members. Ongoing assessments of current residents will be conducted to ensure appropriate interventions are in place to reduce the risk of elopement and to ensure proper documentation is available for team members regarding residents at risk. 3. What measures will be put in place, or what systemic changes will the facility make, to ensure that the deficient practice does not recur: The Executive Director and Director of Nursing received corrective/disciplinary action and re-education on 3/19/25 by the Regional Director of Operations. All community staff members were re-trained on Resident Rights, Abuse, Neglect, and the Elopement Policy and Procedure. The Director of Nursing and/or designee will update each resident's Elopement Risk Assessment every 90 days or upon a change in condition. Audit results and any changes in resident risk will be reviewed during weekly meetings and shared with the regional leadership team. 4. How the corrective action(s) will be monitored to ensure the	

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	wandering the hall anxiously near a room a few doors down from hers. She went to other apartments and tried to open the doors. A nursing progress note, dated 3/5/25 at 9:30 p.m., indicated the resident was wandering in the back hall without pants. She was redirected back to her room. A nursing progress note, dated 3/5/25 at 11:30 p.m., indicated the resident went to the front lobby wearing only underwear and a sweater. She was redirected back to her room. A nursing progress note, dated 3/6/25 at 7:45 a.m., indicated the resident was not in her room. The staff searched the building and found Resident B asleep on the couch in a room a few doors down from hers. A nursing progress note, dated 3/6/25 at 12:00 a.m., indicated the resident went down to the dining room with only underwear and sweater on while carrying a cushion to a chair. The staff redirected the resident back to her room to put her pants on. A nursing progress note, dated 3/6/25 at 1:30 a.m., indicated the resident in another room placed a pendant call. Resident B was in his room and startled him. Resident B would not exit his room until staff arrived. The staff redirected the resident back to her room. A nursing progress note, dated 3/7/25 at 8:45 p.m., indicated the resident was wandering after her helper left. A nursing progress note, dated 3/10/25 at 2:45 a.m., indicated the resident was wandering the		deficient practice does not recur (i.e., what quality assurance program will be implemented): The Executive Director and Director of Nursing will be responsible for ongoing compliance. The Director of Nursing and/or designee will audit 5 resident MMSE (Mini-Mental State Examination) scores weekly for four weeks, biweekly for the following four weeks, and then monthly for 3 months to ensure appropriate risk interventions are in place to maintain resident safety and minimize the risk of elopement. Results will be reviewed weekly by the Executive Director and Director of Nursing. Quarterly elopement drills will be conducted for 6 months to ensure training for staff members. The regional and community leadership teams will determine whether continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. The Executive Director and/or Director of Nursing will report all MMSE scores below 18 to the regional leadership team to assess next steps regarding level of care and appropriateness of the current setting. 5. By what date will the systemic changes be completed? Completion Date: 5/22/25	

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	halls with her dog. A nursing progress note, dated 3/10/25 at 1:15 p.m., indicated the staff was completing a lunch reminder when the resident came out of her room with a pair of pajama pants wrapped around her dog's midsection to take the dog outside. She then tried to take her dog out of the 101-exit door. The staff redirected the resident to her room to get her dog's leash and walked her to the west side courtyard door. A nursing progress note, dated 3/11/25 at 10:45 a.m., indicated the resident had her room packed and the bed stripped. A nursing progress note, dated 3/11/25 at 1:45 p.m., indicated the resident was looking for her driver. The staff invited Resident B to crafts, but the resident refused. The staff took the resident to her room. The progress notes did not include documentation to show staff effectively implemented interventions to prevent elopement or had notified her responsible family member of her escalating elopement behaviors. During an interview, on 4/9/25 at 10:15 a.m., the former Director of Nursing who worked at the facility during the time of the incident indicated he was told Resident B went out of the kitchen door. The resident was found at a salon and brought back by a salon customer. The resident had not lived at the facility very long before she "got out". Resident B was very confused, had been found in other residents' rooms and had multiple behaviors prior to her exiting the building. The resident was not appropriate to be at the facility, had always wanted to leave and was found in other residents'			

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	rooms. During an interview, on 4/9/25 at 10:32 a.m., CNA 5 indicated she had just returned from a break and had received an updated report from another staff member when her pager went off. CNA 5 looked at her pager to see who needed help. She noticed an "old page" from the 101-exit door. CNA 5 had noticed Qualified Medication Aide (QMA) 6 was taking the trash to the dumpster from the 101-exit door. Some staff would prop the door open with a rock. The door locked, and you would not be able to get back in. CNA 5 indicated she was told the resident went out the kitchen door, but she could not see how the resident could have gone out the kitchen door. The kitchen staff were in the kitchen all the time. During an interview, on 4/9/25 at 10:25 a.m., Resident B's son indicated Resident B had a caregiver at home before she was admitted to the facility. After Resident B moved to the facility, she became more confused and disoriented. On the day of the incident, he indicated he received a call from a real estate agent. The real estate agent was concerned about Resident B's confusion and safety. Resident B had walked to a real estate agent's building thinking it was a bank. Resident B had told the agent she went to a store and was looking for her truck. The agent told the son they spent at least 20 minutes looking for the resident's truck before she realized the resident probably did not have a truck. The real estate agent had asked Resident B if she could call someone for her and had found his phone number. The son told the agent he was driving a truck and was out of town. The agent offered to return the resident to the facility. The agent was very worried about the resident and was concerned about her safety walking on the busy street. The agent returned			

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	Resident B to the facility. The Executive Director (ED) then called him approximately two hours later and informed him the resident needed to be picked up and could not remain in the facility. The son was not sure how long the resident was out wandering around, and indicated Resident B should have never left the building by herself. During an interview, on 4/9/25 at 11:10 a.m., the Regional Dietary Manager indicated a staff member was always in the kitchen and the back door remained locked. The door would not open unless you put in a door code. When you pushed on the door, an alarm went off and then sent a message to the staff's pager to alert them that the door had been activated. During an interview, on 4/9/25 at 11:15 a.m., Dietary Manager 3 indicated she worked on the day of the incident. Resident B did not exit the building through the kitchen door. The kitchen doors were unlocked during the day and locked at night. The facility did not have cameras. Dietary Manager 3 told the Executive Director that Resident B did not get out through the kitchen door. During an interview, on 4/9/25 at 11:20 a.m., Cook 4 indicated he worked the day of the incident. Resident B was not in the kitchen while he was there. The kitchen door had a code which had to be entered. During an interview, on 4/10/25 at 2:11 p.m., the real estate agent indicated Resident B approached her while she was standing in the parking lot. The resident appeared very disheveled and confused. The resident indicated she had lost her truck and could not find it. The resident appeared lost. The agent told Resident B she would help her look for			

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	her truck. The agent indicated she quickly realized the situation was much more serious than she had originally thought and asked the resident if there was someone she could call. The agent was able to get Resident B's son's phone number from the phone in the resident's purse. The agent explained to the son the resident was very disoriented and wanted to know what to do. The agent indicated she was very concerned about the safety of the resident. The roads were very busy and not safe for Resident B to walk alone. The son explained the resident was from the facility down the road. The agent asked the son if she could take her back to the facility. When they arrived at the facility, the door was locked so she rang the doorbell. The staff opened the door and looked surprised and shocked to see the resident with her. The agent explained to the staff she had found the resident very confused and in the parking lot of her building. The agent indicated she was with the resident for approximately 20 minutes before she took her back to the facility. A facility document, titled "Missing Resident In-Service," dated as revised 1/15/23, indicated residents with Alzheimer's disorder and related dementia disorders should automatically be considered at risk of elopement. People living with dementia may exhibit signs indicating they were at risk of eloping. These signs include saying they need to leave or are leaving, restlessness, agitation, disoriented in their environment and they are looking for something. 80% of "chronic wanders" end up eloping. Residents who are within their first weeks of moving into the community are at higher risk of eloping. A current facility policy, titled "Elopement Risk Policy & Procedures," dated as revised 6/13/23 and received from the Interim Director of Nursing			

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	(DON) on 4/8/25 at 2:09 p.m., indicated "...If a Resident is determined to be at risk for elopement, a plan will be developed and implemented and will be reviewed with the care team...When an elopement or elopement attempt occurs, an Elopement Root Cause Analysis will be completed within 48 hours of elopement...exit doors are alarmed properly and remain on 24 hours a day...Door codes (if applicable) will be changed periodically in case there are Residents that can manage the door codes...." A current facility policy, titled "External and Secured Doors Policy & Procedures," dated as revised 5/22/24 and received from the Interim DON on 4/8/25 at 2:15 p.m., indicated "...All Assisted Living external doors and courtyard doors are to be locked from sunset to sunrise or up to the discretion of the Regional Director of Operations and Executive Director...Staff should respond as quickly as possible to all non-delayed egress pager alerts. Nursing staff should have pagers on them at all times during their shift...The Environmental Services Director will check all doors, alarms, and delayed egress doors regularly for proper operation...." This citation relates to Complaint IN00455363.			