STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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 the Investigation of Complaint IN00455803. Complaint IN00455803 - State deficiencies related to the allegations are cited at R0052. Survey date: March 21, 2025 Facility number: 000010 Residential Census: 38 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed March 21, 2025.	R 0000	Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and Plan of Correction. Greenwood Village South reserves the right to challenge, in legal proceedings, all deficiencies, statements, findings and facts and conclusions that form the basis of the deficiency. This Plan of Correction serves as our credible allegation of compliance.	
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 protect the resident's right to be free from neglect for a cognitively impaired resident who had been having exit seeking behaviors from exiting the facility for 1 of 3 residents reviewed for elopements. This deficient practice resulted in Resident B walking 1.1 miles away from the facility before being found by the police. (Resident B) Findings include: During an interview, on 3/21/25 at 8:45 a.m. Licensed Practical Nurse (LPN) 1 indicated she was Resident B's nurse for day shift, on 3/18/25. LPN 1 left the facility before Resident B left. Resident B had been having exit seeking	R 0052	I Resident B experienced no harm from the wanderguard not alarming at the door, nor from the resident service plan not being updated with the application of Resident B's wanderguard. The elopement assessment was updated with the application of Resident B's wanderguard and there were orders added to check both function and placement with the application of Resident B's wanderguard. It is the policy of GVS for all licensed residential residents to have a service plan initiated prior to admission and	04/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Seegers	04/08/2025	04/08/2025

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	behaviors before leaving the facility. She packed belongings early that day but didn't get dressed to leave nor say anything to anyone about leaving. The clinical record for Resident B was reviewed, 3/21/25 at 9:15 a.m. Diagnoses included, but were not limited to, dementia and anxiety. An admission assessment, dated 1/9/25 at 4:10 p.m., indicated Resident B was admitted for respite care, did not show any behaviors during the admission process, nor had a history of using alarms for elopement risk. An elopement risk eval, dated 1/9/25 at 4:12 p.m., indicated Resident B was moderately cognitively impaired with poor decision making, and required cues and supervision. Resident B was not at risk for an elopement, so no interventions were necessary. An elopement risk assessment, dated 1/13/25 at 7:51 p.m., indicated a wanderguard (electronic device, worn by a resident, that sounds an alarm when the resident approaches an exit door) was placed on Resident B due to exit seeking behaviors and wandering. A progress note, dated 3/18/25 at 2:20 p.m., indicated Resident B had more wandering today than usual. Resident B had some aggression with caregivers that morning and during meals. A progress note, dated 3/18/25 at 3:32 p.m., indicated staff were unable to locate Resident B. Resident B was noted on camera leaving the property. The facility was notified, on 3/18/25 at approximately 4:15 p.m., that Resident B had been located by police. Resident B was admitted to the		updated at least semi-annually and upon a known substantial change in the resident condition, or more often at the resident or facility request. II All Residential residents with a wanderguard have the potential to be affected by the door not alarming and when failing to update the service plan upon application of the wanderguard. All the service plans of Residential residents with a wanderguard were audited to ensure they had been updated to include the application of the wanderguard. All Residential residents with a wanderguard had their device checked for placement and function. Contractor for wanderguard system (Circuit Masters) reported to the building on April 25, 2025, to check the entire wander alert system and verified the entire system and all wanderguards were working as they should. III Education provided to all Residential nursing staff regarding the required frequency of completing service plans and when to update the service plan due to a known substantial change in the resident, including the application of a wanderguard. Education will be completed by April 11, 2025.	

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	secured unit at the facility with family consent. The Treatment Administration Record indicated on 3/18/25 the wanderguard was in place and functioning. On 3/21/25 at 9:45 a.m., observation of the video footage of Resident B leaving the facility was completed. On 3/18/25 at 3:31 p.m. Resident B was sitting in the main common area dressed in black pants, a shirt, zipped hoodie, and shoes. Resident B stood up and walked toward the front door. Then, at 3:32 p.m. Resident B walked out the front door of the facility. At 3:33 p.m. Resident B walked to the main driveway exit and toward U.S. Highway 31 until Resident B was no longer in view of the camera. During an interview, on 3/21/25 at 9:49 a.m., the Administrator indicated Resident B was located at the corner of a busy four-way intersection on US Highway 31 approximately 1.1 miles from the facility by the police. The wanderguard did not alarm when Resident B exited the facility. On 3/21/25 from 12:20 p.m. until 12:30 p.m., observation of the area Resident B was located by police was completed. The area was grassy with hills but no sidewalks. The busy intersection was on US Highway 31 and another busy main road. The speed limit was 45 miles per hour. The clinical record lacked an updated service plan after the wanderguard was placed, on 1/13/25. During an interview, on 3/21/25 at 12:10 p.m., the Director of Nursing indicated the service plan was not updated once Resident B was considered at risk for an elopement and the wanderguard was placed, on 1/13/25. The service plan should have		IV Residential Health Services Director or designee will: (1 Audit all service plans of residents that currently have a wanderguard or may have a wanderguard added in the future, to ensure they have been updated and are current, monthly for 12 months. (2 Audit the Daily Wander Tag report that is autogenerated from the wanderguard system every day and address any concerns noted on the report immediately. The results of both audits will be presented to and reviewed by the QAPI Committee monthly for 12 months until consistent substantial compliance has been achieved as determined by the committee. The Administrator, Director of Nursing and Residential Health Services Director will be responsible for sustained compliance.	

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	been updated. On 3/21/25 at 9:00 a.m., the Director of Nursing provided a copy of a facility policy, titled Elopement Policy and Procedure, dated 1/3/18, and indicated this was the current policy used by the assisted living facility. A review of the policy indicated upon return to the facility the nurse will update the care plan. This citation relates to Complaint IN00455803.			