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	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD MANOR	5200 S BURLINGTON DR MUNCIE, IN 47302

(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 IN00370687. Complaint IN00370687 - Substantiated. State Residential Findings related to the allegations are cited at R0052. Survey date: January 27, 2022 Facility number: 000312 Residential Census: 24 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on February 2, 2022.	R 0000	R-0000 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
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 failed to ensure a resident displaying abnormal behaviors received the supervision to prevent elopement from the facility for 1 of 3 residents reviewed for elopement (Resident B). This failure resulted in the resident being outside the facility without supervision for an unknown period of time. Findings include:	R 0052	R-0052 What corrective action will be accomplished for those residents found to be affected by the deficient practice? - Resident B has been transferred to a skilled, secure facility	02/25/2022

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

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	The clinical record for Resident B was reviewed on 1/27/2022 at 9:47 a.m. Diagnoses included, but were not limited to, anxiety disorder, depression and paranoid schizophrenia. Review of an un-timed progress note, dated 1/8/2022, at approximately 3:00 a.m. Resident B was discovered missing during bed check. The resident was located and re-directed back to the facility. The resident was assessed and no injury was found. The facility notified the Administrator and physician. The resident was placed on 15 minute checks. A urine sample was collected and sent out for a stat urinalysis. Review of a fax physician notification sheet, dated 1/8/2022 indicated "Resident eloped from facility at 3:00 a.m. on 1/8/2022 and returned safe. Increasing confusion/behaviors previous several days leading up to, including calling 911 x 3 evenings with random complaints 7 delusions." Review of the facility incident report, dated 1/8/2022, a staff member was in the basement doing the laundry and did not hear the door alarm. Prior to going to the basement the staff member did a bed check. When the staff member returned to the main floor and heard the alarm she did a bed check and discovered Resident B was missing. The staff member checked the exit doors and discovered the resident outside near the staff parking lot. The staff member was able to re-direct the resident back into the facility without incident. During an interview on 1/27/2022 at 9:13 a.m., the Administrator indicated staff had contacted her via text and reported the Resident B had left		How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? - All residents have the potential to be affected. All residents will have a baseline Elopement Risk Assessment completed and appropriate measures implemented as needed in accordance with facility policy What measures will be put in place or what systemic changes will be made to ensures that the deficient practice does not recur? - Facility Pre-Assessment and Elopement Risk assessment have been revised to include a baseline Elopement Risk Assessment at the time of admission and subsequent assessments completed every 6 months and any time a sudden or unexpected change in behavior or cognitive status occurs. Staff was in-serviced on the Revised Resident Elopement process on 1/8/2022 How will corrective actions be monitored? - The Director of Nursing or designee will audit Elopement Risk Assessments weekly x's 8 weeks and then monthly for 4 months thereafter. Results of audits will be reported to the Administrator.	

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	the facility around 3:00 a.m. The resident had been found at the end of the staff parking lot walking on the road. She indicated the facility had been watching Resident B because she had not been acting herself for the past week. The Administrator indicated staff should have called her and not left a text. The Administrator also indicated the facility was not a locked building and they had not had elopement issues prior to this incident. The facility had now developed new interventions for such incidents. The staff member involved in incident could not be reached for interview. The resident was currently out of the facility after a fall. Resident was sent to the hospital after a fall on 1/10/2022 and admitted to a skilled facility for rehabilitation. The Administrator indicated she had been looking for alternative placement for the resident prior to her fall due to her change in behaviors. The facility plans to readmit the resident once they completed their rehabilitation an reached their baseline mental status. During a history check on weather. com, indicated temperatures on 1/8/2022 between 12:00 a.m. and 6:00 a.m. were 16-18 degrees Fahrenheit. The length of time the resident was outside could not be determined by documentation. The facility sits back from the road. The road is winding and little to no lighting. The area across the road from the facility is heavily wooded with uneven ground and ditches. The witnessing staff member could not be reached for interview. No other information was provided prior to exit from the facility. This State tag relates to Complaint IN00370687.			

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