DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 00 B. WING	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00383776. Complaint IN00383776 - Substantiated. State Residential Finding related to the allegations is cited at R0052. Survey date: July 5 and 6, 2022 Facility number: 005954 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 8, 2022	R 0000	**Plan of Correction for Springhurst Health Campus** R000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey dated July 5 and 6, 2022. Please accept this Plan of Correction as the provider’s credible allegation of compliance as of July 29, 2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. If you need any information or paperwork, please contact me at (317) 318-0413.	

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 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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			Sincerely, Carrie VanVelse, Executive Director	
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 adequate supervision was provided to prevent the elopement from the facility of a resident with an identified risk for elopement and a recent history of exit-seeking behaviors for 1 of 3 residents reviewed for elopement risk. (Resident B) Findings include: In an interview with CNA 5 on 7-5-22 at 5:05 p.m., she indicated she was working on the evening of 6-19-22, estimated at around 8:00 p.m., when Resident B had eloped from the secured dementia unit. She indicated she had last seen him asleep in his room, prior to going to assist another resident. She indicated she was leaving the other resident's room and heard the door alarm, indicative of a secured door being opened. She shared she went down towards Resident B's room and was unable to locate him in his room. "I did a full head count and did not find him. You have to	R 0052	R 052 410 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. This RULE is not met as evidenced by: R 052 Based on interview and record review, the facility failed to ensure adequate supervision was provided to prevent the elopement from the facility of a resident with an identified risk for elopement and a recent history of exit-seeking behaviors for 1 of 3 residents reviewed for elopement risk. (Resident B)	07/29/2022

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	remember he has a history of wandering. I was alone in the building, after the nurse left between 7 pm and 7:30 pm. Typically, [we] try to staff with at least 2 staff for all of evening shift, but that doesn't always get to happen. When I couldn't find him, I did a quick look around outside and then called the other building [for assistance]." She indicated at about the same time, Resident B's wife called the facility to say Resident B had walked to a home in a nearby housing addition and the person who lived there had obtained information with the spouse's phone number and had called her, regarding Resident B's location. CNA 5 indicated two nurses from the other building immediately came to provide assistance and about the same time, two officers from the local police department, as well as the homeowner at whose home Resident B had walked to, arrived to return the resident to the facility. She indicated the homeowner said he was outside in his garage and Resident B just wandered up to him. She added the homeowner had called the local police for assistance with Resident B. She indicated she did later go and see where Resident B had eloped to and discovered it was less than a block away from the secured memory care unit. In an interview on 7-6-22 at 12:05 p.m., with the Corporate Nurse, she indicated the distance from the facility to the address to where Resident B eloped was 0.2 miles, according to her mobile phone's GPS (global positioning system). A limited observation was conducted at this time from the door he exited on 6-19-22. Due to line of tall trees, the address to which Resident B eloped was not visible, but an estimate would be less than a city block. A review of the "as worked" staffing for the secured dementia unit on the evening shift for		1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B no longer resides at the facility. 1.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents residing at The Legacy at Springhurst were re-assessed utilizing our Elopement Observation. Residents identified as being “at risk” had their service plans and resident profiles reviewed and updated as needed to reflect appropriate interventions to minimize the risk for future elopement/exit seeking behaviors. 1.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Staff were provided re-education by the Clinical Support, Legacy Director and DON as to our policy and procedures regarding, “Elopement Risk Assessment & Prevention”, “Elopement Missing Resident Guidelines”, and our manufacturer’s guidelines regarding functional operations of the doors and alarms.	

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	6-19-22, revealed CNA 5 was the only person scheduled for the time period of 7:30 p.m. to 11:00 p.m. A review of Resident B's clinical record on 7-5-22 at 3:03 p.m., indicated he was admitted to the facility in February of 2022, with diagnoses which included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbances and agitation and mild cognitive impairment. His admission evaluation and initial service plan, dated 2-28-22, indicated he was severely cognitively impaired, he was an elopement risk related to a history of exit seeking, voiced a desire to leave and exhibited periods of pacing, agitation or wandering toward exits and he was independently ambulatory. A review of the progress notes indicated in the weeks prior to the elopement on 6-19-22, Resident B demonstrated multiple exit-seeking behaviors in which he would push on the bar on the secured doors, causing it to alarm and within 15 seconds would unlock the door. On 6-6-22, he was found immediately outside of the front entrance of the facility. Facility staff were alerted to this by the entrance door alarms sounding and were able to re-direct Resident B back into the facility. On 6-9-22, Resident B was documented to have made multiple attempts at exit-seeking by pushing on the secured doors until the alarms would sound. On this same date, Resident B was able to push on the alarmed security door on the south side of the unit until the door opened, allowing him to exit the facility. The resident was promptly attended to and was able to be re-directed back into the facility. This Residential tag relates to Complaint IN00383776.		LED or designee will complete new LD assessment for any residents who have exit-seeking behaviors and look for additional activities to keep them engaged. 1.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Legacy Lane Coordinator and/or Designee will review residents identified as being "at risk" for exit seeking/elopement behaviors per the Exit Seeking/Elopement Observation for no less than three times a week, for a period of six months. Residents who have been identified and/or demonstrate exit seeking/ elopement behaviors will be reviewed to ensure appropriate interventions are implemented via their service plans and resident profile sheets to minimize their risk for elopement/exit seeking behavior. Findings will be reviewed monthly during the facility QAPI meetings. Findings suggestive of 100% compliance may result in cessation of the monitoring plan.	

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	410 IAC 16.2-5-1.2(v)(5)		1.By what date the systemic changes will be completed. */i>* *="" span="">*	