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	11/10/2022

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00393587. Complaint IN00393587 - Substantiated. State deficiencies related to the allegations were cited at R0052. Survey date: November 10, 2022 Facility number: 004441 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 18, 2022.	R 0000		
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 observation, interview and record review, the facility failed to ensure a resident with a diagnosis of vascular dementia was free from neglect, when she and her cat was let out of the facility by a staff member and wandered away from the facility grounds, without the staffs' knowledge of her whereabouts for approximately two hours and 15 minutes prior to a police officer bringing her back to the facility for 1 of 3 residents	R 0052	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other*	12/10/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Sailors	Executive Director	12/06/2022

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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	reviewed for neglect (Resident B). Finding includes: During an interview, on 11/10/22 at 1:25 p.m., the Executive Director (ED) was notified on 10/29/22 at approximately 9:30 p.m., by LPN 5 Resident B had eloped from the facility and was returned by Police Officer 6. At that time, she was not sure how the resident had exited the facility. After further investigation, without any conclusion as to how the resident could have eloped, she called QMA 4 and asked if he knew how Resident B and her cat could have left the facility. QMA 4 indicated he had let someone and her cat out of the facility earlier in the evening. He did not know she was a resident living at the facility. The ED indicated Resident B, while carrying her cat, wandered away from the facility, on 10/29/22 at approximately 7:00 p.m. She walked to a convenience store, which was 0.4 miles from the facility (mileage obtained by Google maps). She was away from the facility for approximately two hours and 15 minutes before Logansport Police Officer (LPO) 6 brought her back to the facility at 9:15 p.m. The temperature, on 10/29/22, ranged from a low of 50 degrees Fahrenheit (F) at 9:15 p.m., and a high of 55 degrees F at 7:35 p.m. The sun had set and darkness had set in at 6:55 p.m., and the wind was blowing at three to five miles per hour (mph) (All the data for the temperature, how light it was for that time of the day and how windy it was, was obtained from the timeanddate.com app.) The investigation for the elopement of Resident B, provided by the ED on 11/10/22 at 1:30 p.m., indicated:		*individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.* **R 052 Residents' Rights - Offense** ="" span ="" span="">Resident B remains on frequent checks. Resident B was assessed by in house psychiatric services on November 4, 2022 and a new medication was prescribed. A new assessment was completed on resident B on November 1, 2022, including elopement evaluation and the service plan was updated to reflect appropriate interventions to decrease risk of elopement **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of the elopement risk assessment tool for current residents will be completed by December 9th by the Care Services Manager (CSM) to ensure residents at risk for	

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	An "Intake Information" document, dated 11/2/22, indicated an elopement event involving Resident B occurred on 10/29/22 at 9:15 p.m. Resident B, who had a diagnosis of vascular dementia, exited the facility unbeknownst to the current staff working the evening shift and she was returned by the local police. After an investigation, it was determined a staff member "accidentally" let the resident out of the facility with some other visitors because he thought she was also a visitor. A typed and signed statement by LPN 5, dated 10/31/22, indicated the interview took place on 10/29/22 at 10:30 p.m., in person. She indicated the last time she seen Resident B on 10/29/22 was between 6:30 p.m. and 7:00 p.m., when she administered her medications to her. She did not know the resident had been let out of the facility and left the facility property until LPO 6 returned her to the facility between 9:00 p.m. and 9:15 p.m. A typed and signed statement by CNA 7, dated 10/31/22, indicated the interview took place on 10/31/22 at 3:52 p.m., in person. She indicated the last time she seen Resident B on 10/29/22 was between 6:30 p.m. and 7:00 p.m., when she delivered her supper tray to her room and the resident declined to eat the tray. She was not aware the resident had left the facility until she was returned to the facility at approximately 9:00 p.m. A document, titled "Navigating to Success Growth Discussion Form," dated 10/31/22, indicated the discussion type was Positive Reinforcement. The document indicated the goal behavior was to ensure QMA 4 understood who each visitor was, he allowed to leave the facility. The reality indicated QMA 4 "mistakenly" allowed a resident to exit the facility because he thought		elopement are identified with interventions reflected on the plan of care. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The CSM was reeducated by the Regional Director of Care Services on 12/1/2022 on the need to ensure the elopement risk assessment tool is completed for residents upon move and quarterly and any newly identified elopement risk will be noted on the plan of care with interventions initiated. Current staff was reeducated on 11/28/2022 by theED on the community visitor sign in and out policy and the need to ensure residents are free from neglect. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The ED or designee will audit the community visitor sign in and sign out log to ensure the tool is complete. The audit will occur weekly for four weeks, biweekly for four weeks, then monthly for one month. The CSM or designee will audit the elopement risk assessment for new residents and 5 current residents to ensure	

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	she was a visitor. The options were to make sure each person leaving the facility signed out of the facility and was accounted for. If he was unsure of who the person asking to leave was, then he should ask a few questions. The Way Forward indicated he should familiarize himself with each resident in the facility even though he did not provide direct care to them. A document, titled "Logansport Police Department Incident Report for Incident (Incident # given)," dated 11/10/22, indicated LPO 6 was dispatched to a local convenience store on 10/29/22 at 8:21 p.m., for the problem of a female with mental instability. The "Affirmation Narrative" written by LPO 6 indicated on 10/29/22 at 8:21 p.m., he was sent to a local convince store regarding an elderly woman in the parking lot with her cat. The caller indicated the woman was in their parking lot for over an hour with her cat waiting for her daughter to come pick her up. When LPO 6 arrived at the convenience store, he found a female and her cat, who he later identified as Resident B in the parking lot. When he ran her name through the Cass Central Dispatch system, he was advised she had a caution indicated for dementia and he was advised of her home address. He attempted several times to ask her how she arrived at the convenience store and where she lived, but she "appeared lost" and was unable to answer his questions. He transported Resident B and her cat to her home address, but she indicated she did not recognize the address. He had her and the cat wait in the patrol car while he knocked on neighbors' doors. He found a neighbor to talk to, who told him Resident B had moved to (Name of Facility) sometime ago. He asked the resident if she remember (Name of Facility) and she indicated she did not. He transported her back to the facility and spoke to		residents at risk for elopement are identified with interventions reflected on the plan of care. The audit will occur weekly for four weeks, biweekly for four weeks, then monthly for one month. Audit results will be reviewed at monthly QI meeting. The QI Committee will determine if continued audits are necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed** Completion date: December 10, 2022	

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	LPN 5, who indicated the resident did live at the facility, but she had no idea Resident B had eloped from the facility and she was not sure how she got out. He walked the resident and her cat to her apartment and she did recognize it. On 11/10/22 at 2:50 p.m., Resident B was observed in her apartment with her daughter and great-grandson visiting with her. Her daughter asked the resident if she remembered anything about the day she and the cat went outside and the police brought her back to the facility. The resident indicated she did not know she did that. She had a large sized orange colored cat lying on her bed sleeping. Resident B indicated it was her cat and he weighed 18 pounds. She was disoriented to time and place. She was steady on her feet and she had a fast step when she walked around in her apartment. Her daughter indicated she did not have problems walking and she could walk at a fast speed. Her problem was her memory. On 11/10/22 at 3:16 p.m., Resident B's daughter indicated Resident B eloped from her house and the local police picked her up from the side of Highway 24 just prior to her moving into the facility. She was living with her son in her house who was asleep when she exited the house. She thought her son was killing babies and cats in the basement of her house and she would not return to her home. The police called an ambulance and this daughter picked her up on the side of Highway 24 from an ambulance. She stayed with her other daughter until the family was able to find a facility which was completely locked down 24 hours a day, 7 days a week to prevent her from exiting the facility. She indicated she was not the POA (Power of Attorney), so she did not do the admission paperwork, but as far as she knew the facility was told about the resident eloping from			

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	her home before being admitted to the facility. The record review for Resident B was reviewed on 10/29/22 at 3:30 p.m. Diagnoses included, but were not limited to, dementia, fall risk, transient ischemic attack (TIA), PVD (Peripheral Vascular Disease) and asthma. A Nurse Practitioner's note, dated 8/11/22, indicated the resident had mild to moderate cognitive impairment. Her memory loss was described as her inability to recall recent conversations, recent events, words and dates. The severity was considered mild to moderate and occurred frequently. A document, titled "Psychiatry Initial Consult," dated 9/15/22, indicated Resident B had distractibility and cognitive impairment. She was ambulatory. Her short term memory was impaired. Her judgement had mild impairment. A document, titled "Assessment/Negotiated Service Plan Summary," dated 9/28/22, indicated the facility licensed nursing staff needed to administer her medications to her, she needed reminders as well as assistance to set up and prepare her bath or shower (set-up her supplies and adjust the water) before she was able to bathe. She required reminders to dress and/or groom. She had difficulty recalling the day, date time and the location she lived at. A document, titled "Folstein Mini Mental Exam," dated 9/28/22, indicated her score was 11. Scoring indicated a score of 24 or above was considered normal. On the place and orientation question she did not answer the town, facility, room or floor correctly.			

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	A document, titled "Elopement Risk Assessment," dated 9/28/22, indicated her score was 22. Any score 29 and below did not have a rating on the Guidelines for Interpreting Scores. The first item under the Guidelines for Interpreting Scores was "Any Bold Item" The Guideline for Interpreting Scores for this item was "Even one of these items indicated a potential for elopement and requires consultation with the regional team and appropriate intervention. There were two bolded areas on her form marked, which were "Mini-mental score less than 20 or GDS 4 or higher" and "Diagnosis of dementia, Alzheimer's Disease, Parkinson's or recent stroke." The progress notes, the elopement risk assessment dated 9/28/22, nor the Service Plan dated 9/28/22, had documentation to indicate the two bolded areas on the elopement risk assessment were discussed and interventions were initiated to prevent the resident from eloping from the facility. A progress note, dated 10/29/22 at 10:00 p.m., indicated Resident B was returned to the facility at approximately 9:15 p.m., by a LPO after she left the facility with other visitors without the current evening shift staff knowing she left. A progress note, dated 10/29/22 at 11:30 p.m., indicated after further investigation, a discovery was made Resident B was "accidentally" let out of the facility by a staff member while opening the door for another family who was exiting. During an interview, on 11/10/22 at 4:10 p.m., QMA 4 indicated he was on the front hall passing his mediations at approximately 7:00 p.m. A gentleman came up to him and asked if he would let him and 2 other visitors out the front door of			

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	the facility. He let three people out and one of them was a lady carrying a large sized cat, which he now knows was Resident B. He went back to passing his medications. He left for the end of his shift at approximately 8:45 p.m. The ED called him, on 10/29/22 in the evening after 9:30 p.m., and asked him if he he let a woman with her cat out of the facility. He indicated he had let a woman with a hat, coat and a large cat out of the facility at approximately 7:00 p.m. He was told he let Resident B out of the facility and she was brought back by the police approximately 2 hours later. During an interview, on 11/10/22 at 4:35 p.m., the ED and Director of Nursing (DON) indicated neither of them were aware Resident B had gotten out of her home and onto Highway 24 shortly prior to being admitted to the facility. The ED indicated had she known that, she would not have taken the resident because she would have been to high of a risk for the facility and they did not have a memory care unit. A current policy, titled "Elopement or Missing Resident Policy," dated 3/01/22 and provided by the ED on 11/10/22 at 4:58 p.m., indicated "Policy: It is the policy of Enlivant to provide a systematic effort of all community staff to search when a resident is reported missing and that person is cognitively impaired and leaves the community without staff knowledge and or supervision, lacks safety awareness and is unable to distinguish/identify his or her safety needs and/or has impaired appropriate decision making ability Procedure: First Response Plan (IMMEDIATE ACTION) 1) A resident is considered missing when he or she leaves the community undetected and without notice to the community by writing in the Sign-out Log...."			

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