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	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT HARRISON ALF OPERATIONS	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00429229, IN00430790 and IN00434051. Complaint IN00429229 -- No deficiencies related to the allegations are cited. Complaint IN00430790 -- No deficiencies related to the allegations are cited. Complaint IN00434051 -- Residential deficiencies related to the allegation are cited at R0052, R0090 and R0214. Survey dates: May 28 and 30, 2024 Facility number: 014109 Residential Census: 59 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 4, 2024	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 interview and record review, the facility failed to ensure a cognitively impaired resident did not elope from the facility and facility grounds for 1 of 1 residents reviewed for elopement. (Resident	R 0052	1. Immediate Action taken for resident	07/12/2024

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

Dametria Marshall | Executive Director | 07/12/2024

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	B) Findings include: The clinical record of Resident B was reviewed on 5-28-24 at 12:45 p.m. Her diagnoses included, but were not limited to cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, unspecified dementia, speech disturbances, hemiplegia, anxiety, cerebrovascular disease and high blood pressure. Her most recent assessment of her cognitive abilities, dated 10-8-23, indicated she has mild cognitive impairment. An evaluation of her mobility abilities, dated 5-28-24, indicated she is independently mobile [ability to ambulate/walk without assistance]. In review of nursing progress notes, dated 5-5-24 at 6:53 p.m., indicated, "Staff notified writer [Director of Nursing] via phone call of resident taking an early evening walk. Staff notified to ask for a staff member to join her and to sign out before leaving the building. Staff did join resident for her evening walk, Administrator notified via phone call." In an interview with CNA 3 on 5-30-24 at 9:38 a.m., she indicated she was familiar with Resident B, as she has worked at the facility for nearly one year. She recalled on the evening shift of 5-5-24, Resident B had eaten in the dining room and dining services were at/near completion when she took her dinner break around 5:20 p.m. CNA 3 indicated she observed Resident B was sitting in a gray chair in the common area, near the front entrance, upon leaving the facility for her break. CNA 3 indicated, "When I was returning, I saw her turning [walking] off of Drum [Street] onto 56th [Street], heading west onto 56th [Street]. I		Once resident back at the facility, staff took vitals, called family and physician. staff made sure resident was safely placed in residents' room and placed on frequent checks. 2. How the facility identified other residents resident was also placed on 30 min checks and hourly checks until home health start or until residents moves with family for 7 days 3. Measures put in place or system changes ED had Maintenance Director have an in-service on elopement drill on all three shifts. Will continue education monthly for staff 4. How the corrective action will be monitored community also reached out to family to have home health come and sit with resident 8 hours a day at 7 days a week	

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	parked my car and went got [name of QMA 4], the nurse on duty. We walked down to get her. She had not made it the light at Franklin [Road]. This was around 6:15 to 6:30 p.m., [it was] still light out...When I stopped my car and went to get the nurse, one of the residents told me [name of Resident B] had gotten out of the building and she had turned to the right. "She couldn't tell us where she was going or what her plans were." CNA 3 indicated she had contacted the Director of Nursing (DON) by text and phone call and was aware QMA 4 had also notified the DON about Resident B leaving the grounds unescorted. CNA 3 indicated Resident B has limited speech communication due to a previous stroke. "She is aware sometimes, some days better than others. To me, her cognition seems worse since last fall. She used to be able to go to the dining room by herself, but anymore, we have to help her; we've noticed she eats very little if she isn't where we can encourage her." CNA 3 was unable to recall Resident B ever leaving the building unescorted before. "I think she just wanted to be out in the fresh air. I did tell her to let us know if she wants to go outside and we would be able to help her, but [I] don't think the resident would recall being told this, due to her poor memory." In an interview with QMA 4 on 5-30-24 at 11:28 a.m., she indicated she was familiar with Resident B, as she has worked at the facility for over one year. "Her leaving the grounds has been an issue in the past, but never known her to get so far." QMA 4 indicated on 5-5-24, at approximately 6:00 p.m. to 6:30 p.m., she had just started med pass when CNA 3 informed her Resident B was off the facility's premises and walking west on the sidewalk on 56th Street, toward Franklin Road. " I had never seen her get so far, we found her on the			

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	sidewalk on 56th Street and was very close to the light on Franklin Road. 56th street is a very busy street and we had to run down the hill to get to her before she got to the intersection and crossed the street...She seemed to recognize us and she walked back with us, even though she initially said 'no.' It took us nearly 30 minutes for us to get back to the building, because she walks very slowly. She seems to have gone downhill with her cognition and understanding since she has been here." QMA 4 indicated Resident B can only say a few words, she can't explain what she was doing, she just wanted to be outside and this was not unusual for her to leave the building. She indicated Resident B seems to have gone downhill with her cognition and understanding since she has been here. QMA 4 indicated she immediately notified the DON, while she, CNA 3 and Resident B were walking back to the facility. She indicated after this incident, facility management initiated having the main doors locked all the time. In an interview with the Executive Director on 5-30-24 at 1:15 p.m., she indicated after Resident B was brought back to the facility, we talked to her about letting us know if she is wanting to go out and we will be happy to go with her. "Now to be honest, I don't know that she has the ability anymore to remember to do that." She added the facility began having the main entrance doors locked from 5:00 p.m. to 8:00 a.m. "This did not go over very well with the other residents. So we changed that to the doors being locked from 7pm to 9am. The residents that have the ability to come and go and are not a concern for cognition problems, have the codes to get in and out as they please."			

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	In an interview with DON on 5-28-24 at 1:50 p.m., she indicated earlier this month, Resident B left the building without telling staff or signing out and was later found on 56th Street, below the building, but in front of the facility taking a walk. The DON was unsure of how long Resident B was out of building and unaccounted for, but estimated it was less than one hour. The DON indicated she was unsure of exactly what path the resident may have taken to get to 56th Street. She indicated the facility staff are good to check on her frequently, at least hourly, especially on nice, sunny days as she likes to walk outside. The DON indicated after the facility staff notified her of the resident leaving the grounds unsupervised, and she then notified the Executive Director (ED) of the event. She added the ED suggested to institute supervised walks with Resident B on nice days. The DON Indicated she was not aware if a state reportable was filed. The DON described Resident B as having aphasia and her verbiage is limited; the resident is able to nod her head yes and no to indicate if she understands what you are saying to her, but is unsure if someone were to ask her where she lived if she could tell them. The DON indicated Resident B is able to ambulate independently without devices. On 5-30-24 at 9:54 a.m., the Business Office Manager provided a copy of an undated policy entitled, "Elopement Drill." This policy indicated its purpose as, "[To] Protect residents who wander from the community and prepare associates to help prevent and deal with elopements. The Executive Director of the community is responsible for conducting elopement drills. Suggested Guidelines: Conduct elopement drill monthly (at least annually for each shift or as required by state regulation). Simulate an elopement situation...Check the Sign In/Sign			

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	Out book. During the drill, ask associates who last saw the resident: time seen; what the resident was wearing; what their physical, mental and emotional status was; the above information must be confirmed with a fact to face observation of the resident. Conducted a thorough search of the community: resident units, common areas, closets, stairwell, offices, rest rooms, and grounds. Contact the Executive Director, or designee, who will contact the resident's family/legally responsible party, and if necessary, the police. Provide a picture of the missing resident for police if needed. Consult the Reportable Events policy and Reportable Events Categories/Reporting Time Frames Grid. Evaluate the appropriateness of placement of the resident and update the Personal Service Assessment and Personal Service Plan. Complete an Elopement Drill and Report and file in the Emergency/Disaster Manual." This State Residential tag relates to Complaint IN00434051 2.5-1.2(v)(5)			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual			

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	occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility failed to ensure an incident of elopement was reported to the Indiana Department of Health (IDOH) as an unusual occurrence, related to a cognitively impaired resident leaving the facility's	R 0090	1. what corrective action will be accomplished? resident was place on 30 min and hourly checks on each shift. ED	07/12/2024

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	grounds without supervision for 1 of 1 residents reviewed for elopement. (Resident B) Findings include: In an interview with the Executive Director (ED) on 5-28-24 at 3:26 p.m., she indicated at the time of Resident B left the facility [on 5-5-24], she did not report it to the State, because she "was under the impression that since this is a Residential setting, the residents can come and go as they please and didn't take into account this person had declined in her cognitive abilities and it might be a safety concern." She indicated, "She seems to be able to get around very well inside of the building. In the past, she was able to walk about inside the building and outside the building without any problems. I am not sure how long she was outside without anyone keeping an eye on her. Since then, we have put into place that staff will go outside with her every day that the weather is nice and take her for a walk." She added she did not conduct an investigation into the circumstances of the elopement. The ED shared the staff on duty at the time of the elopement did let the Director of Nursing (DON) and herself know of Resident B being off-grounds at the time. She indicated she has been in this position as ED since last fall and this is the first time an elopement of any type occurred. In an interview with the ED on 5-30-24 at 1:15 p.m., she indicated after Resident B was returned to the facility, facility staff talked to her about informing the staff if she is wanting to go out. "Now to be honest, I don't know that she has the ability anymore to remember to do that...Since this happened, I have learned a lot. This is my first time being an Administrator and this has helped me to have a much better understanding of the		and DON called family to have home health come in and sit with resident 7 days a week around the clock until resident relocates with family out of state. 2. what measures will be put in place to make sure incident want happen again? ED will do monthly triple checks with DON, and BOM to make sure there is no significant change with residents. also make correction to service plan immediately. staff was giving an in-service on what to do and who to call if a resident elopes on all three shift. and will continue education on a monthly basis on going 3. how community will make sure incident does not happen again? ED unaware that she needed to report to state due to this being AL community and residents could come and go as they please. State survey explained to ED why this should have been reported. moving forward ed will refer to state regs if unsure of unusual occurrence. ED and DON will follow up on any changes with residents every 3 months, monthly and on going	

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	regulations and looking at things from a safety perspective." In an interview with DON on 5-28-24 at 1:50 p.m., she indicated earlier this month, Resident B left the building without telling staff or signing out and was later found on 56th Street, below the building, but in front of the facility taking a walk. The DON was unsure of how long Resident B was out of building and unaccounted for, but estimated it was less than one hour. The DON indicated she was unsure of exactly what path the resident may have taken to get to 56th Street. She indicated the facility staff are good to check on her frequently, at least hourly, especially on nice, sunny days as she likes to walk outside. The DON indicated after the facility staff notified her of the resident leaving the grounds unsupervised, and she then notified the ED of the event. She added the ED suggested to institute supervised walks with Resident B on nice days. The DON Indicated she was not aware if a state reportable was filed. The DON described Resident B as having aphasia and her verbiage is limited; the resident is able to nod her head yes and no to indicate if she understands what you are saying to her, but is unsure if someone were to ask her where she lived if she could tell them. The DON indicated Resident B is able to ambulate independently without devices. The clinical record of Resident B was reviewed on 5-28-24 at 12:45 p.m. Her diagnoses included, but were not limited to cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, unspecified dementia, speech disturbances, hemiplegia, anxiety, cerebrovascular disease and high blood pressure. Her most recent assessment of her cognitive abilities, dated 10-8-23, indicated she has mild cognitive			

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	impairment. An evaluation of her mobility abilities, dated 5-28-24, indicated she is independently mobile [ability to ambulate/walk without assistance]. In review of nursing progress notes, dated 5-5-24 at 6:53 p.m., indicated, "Staff notified writer [Director of Nursing] via phone call of resident taking an early evening walk. Staff notified to ask for a staff member to join her and to sign out before leaving the building. Staff did join resident for her evening walk, Administrator notified via phone call." In an interview with CNA 3 on 5-30-24 at 9:38 a.m., she indicated she was familiar with Resident B, as she has worked at the facility for nearly one year. She recalled on the evening shift of 5-5-24, Resident B had eaten in the dining room and dining services were at/near completion when she took her dinner break around 5:20 p.m. CNA 3 indicated she observed Resident B was sitting in a gray chair in the common area, near the front entrance, upon leaving the facility for her break. CNA 3 indicated, "When I was returning, I saw her turning [walking] off of Drum [Street] onto 56th [Street], heading west onto 56th [Street]. I parked my car and went got [name of QMA 4], the nurse on duty. We walked down to get her. She had not made it the light at Franklin [Road]. This was around 6:15 to 6:30 p.m., [it was] still light out...When I stopped my car and went to get the nurse, one of the residents told me [name of Resident B] had gotten out of the building and she had turned to the right. "She couldn't tell us where she was going or what her plans were." CNA 3 indicated she had contacted the DON by text and phone call and was aware QMA 4 had also notified the DON about Resident B leaving the grounds unescorted.			

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	CNA 3 indicated Resident B has limited speech communication due to a previous stroke. "She is aware sometimes, some days better than others. To me, her cognition seems worse since last fall. She used to be able to go to the dining room by herself, but anymore, we have to help her; we've noticed she eats very little if she isn't where we can encourage her." CNA 3 was unable to recall Resident B ever leaving the building unescorted before. "I think she just wanted to be out in the fresh air. I did tell her to let us know if she wants to go outside and we would be able to help her, but [I] don't think the resident would recall being told this, due to her poor memory." In an interview with QMA 4 on 5-30-24 at 11:28 a.m., she indicated she was familiar with Resident B, as she has worked at the facility for over one year. "Her leaving the grounds has been an issue in the past, but never known her to get so far." QMA 4 indicated on 5-5-24, at approximately 6:00 p.m. to 6:30p.m., she had just started med pass when CNA 3 informed her Resident B was off the facility's premises and walking west on the sidewalk on 56th Street, toward Franklin Road. " I had never seen her get so far, we found her on the sidewalk on 56th Street and was very close to the light on Franklin Road. 56th street is a very busy street and we had to run down the hill to get to her before she got to the intersection and crossed the street...She seemed to recognize us and she walked back with us, even though she initially said 'no.' It took us nearly 30 minutes for us to get back to the building, because she walks very slowly. She seems to have gone downhill with her cognition and understanding since she has been here." QMA 4 indicated Resident B can only say a few			

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	words, she can't explain what she was doing, she just wanted to be outside and this was not unusual for her to leave the building. She indicated Resident B seems to have gone downhill with her cognition and understanding since she has been here. QMA 4 indicated she immediately notified the DON, while she, CNA 3 and Resident B were walking back to the facility. She indicated after this incident, facility management initiated having the main doors locked all the time. On 5-30-24 at 9:54 a.m., the Business Office Manager provided an undated policy entitled, "Incident Reporting Policy." This policy indicates, "In the event that a resident or visitor experiences an occurrence, the associate reporting the incident must either complete the Preliminary Draft Notes of a Reported Incident or enter the incident into the Springfield [sic] Assisted Living Automated Incident Reporting System during the shift on the day of the incident in accordance with this policy. In the event that a resident or visitor experience an occurrence such as, not limited to: fall, vehicular transportation incident, resident unaccounted for/elopement...the associate reporting the incident along with the supervisor or management representative, must either complete the Preliminary Draft Notes of a Reported Incident ("Draft Incident Notes") or enter the incident into the Springfield [sic] Assisted Living Automated Incident Reporting System ("BAIRS") during the shift on the day of the incident...The Completed Incident Report should not be printed unless state regulations require a hard copy be kept in a secure, private area that can be locked. This policy does not replace the Reportable Events Policy. The Executive Director, or designee, should notify the appropriate leadership above			

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(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
	the community of occurrences according to the Reportable Events Policy and Procedure and the Reportable Events Categories/Reporting Time Frames Grid." This State Residential tag relates to Complaint IN00434051. 2-5-1.3(g)(1)			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to update resident evaluations every six (6) months, and/or as needed upon change in resident condition, and/or upon request of the resident and/or resident representative or the facility for 2 of 3 residents reviewed for service plans. (Resident B and D) Findings include: 1. The clinical record of Resident B was reviewed on 5-28-24 at 12:45 p.m. Her diagnoses included, but were not limited to, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, unspecified dementia, speech disturbances, hemiplegia, anxiety, cerebrovascular disease and high blood pressure. A review of the service plans for Resident B, indicated the most recent evaluations of the her	R 0214	1. what corrective action community put in place DON will do evaluations every 6 months or if there is significant change. ED and DON will evaluate to make sure this is the proper setting for each resident. ED, DON,BOM will do triple checks monthly to make sure all evaluations updated in a timely manner. 2. what corrective action taken for other potential residents DON will do evaluations every 6 months or if there is significant change. ED and DON will evaluate to make sure this is the proper	07/12/2024

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	05/30/2024

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	capabilities and care needs occurred on 10-8-23, with the next evaluation initiated on 3-28-24, but not finished or "locked" into the electronic medical records until 5-30-24. In an interview ith the Director of Nursing on 5-30-24 at 10:30 a.m., she added it appeared the evaluation for Resident B was started the end of March, but was not completed "until after we talked about it on Tuesday [5-28-24]. We did add some interventions to her service plan on 5-6-24, after she left the building." The time frame from the 10-8-23 evaluation and until the completion of the 5-30-24 evaluation was over seven (7) months. 2. The clinical record of Resident D was reviewed on 5-30-24 at 12:13 p.m. Her diagnoses included, but were not limited to, dementia, cognitive communication disorder, high blood pressure and generalized muscle weakness. A review of her most recent evaluation and service plans indicated she had an evaluation of her capabilities and care needs on 7-10-23, and 4-2-24. This indicated a lapse of over eight (8) months. In an interview with the Director of Nursing (DON) on 5-28-24 at 3:24 p.m., she indicated she has been having problems with getting their computer system to communicate between the various portions of the assessments, evaluations and the care [service] plans. She indicated as a result of this, she has not conducted any assessments or evaluations since last fall, but has been trying to keep the care [service] plans updated. She indicated she plans to discuss this with the corporate staff to see how to get the different aspects of the service plans completed. On 5-30-24 at 1:38 p.m., the Executive Director		setting for each resident. ED, DON,BOM will do triple checks monthly to make sure all evaluations updated in a timely manner. 3. what measures will be put into place DON will do evaluations every 6 months or if there is significant change. ED and DON will evaluate to make sure this is the proper setting for each resident. ED, DON,BOM will do triple checks monthly to make sure all evaluations updated in a timely manner. ED and maintenance will have monthly in-services on elopement. and educate staff on who to call and when. ED and DON will educate staff if staff notice any changes in a residents bx staff is to call DON immediately. 4. who is responsible to monitor any changes? DON will educate staff on when to call and who to call on any incident DON and ED will make sure all changes in residents bx noted in resident service plan immediately. And staff is aware in progress notes daily on going ED, DON,BOM will do triple checks monthly to make sure all evaluations updated in a timely	

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	(ED) provided a copy of an undated document entitled, "Guiding Principles for Assisted Living." This document indicated, "Guiding Principle #5: Services: Services should be delivered in an appropriate and safe setting in compliance with applicable rules and regulations. When moving into an ALC [assisted living community], each resident should be evaluated or assessed to determine how his or her need for services can best be met. Individuals or their representatives should not choose to move into an ALC that is unable to meet the full scope of their needs. A service plan should be developed indicating services that will be delivered to meet the individual needs based on the individual's physical, psychosocial, and cognitive capabilities. The individual, family, or responsible party should be encouraged to participate in the development of the service plan, which should be reviewed and updated regularly and as changes in the resident's condition occur. The ALC should designate who is responsible for developing, implementing, and evaluating the progress of the service plan. A copy of the service plan should be given to the resident and/or responsible party/representative." In an interview with the ED on 5-30-24 at 1:58 p.m., she indicated, "My expectations, as far as service plans, along with the assessments and evaluations, are that our building will follow the State regulations for them to be done as written and as needed." This State Residential tag relates to Complaint IN00434051. 2.5-5-2(a)		manner.	