STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00434869. Complaint IN00434869- Federal/state deficiencies related to the allegations are cited at F689. Survey date: August 5, 2024. Facility number: 000576 Provider number: 155701 AIM number: 100267760 Census Bed Type: SNF: 12 SNF/NF: 51 Residential: 39 Total: 102 Census Payor Type: Medicare: 7 Medicaid: 33 Other: 62 Total: 102 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 6, 2024	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review the facility failed to ensure intervention were implented to prevent elopement for 1 of 4 residents reviewed (Resident B).	F 0689	Please accept the following plan of correction and consider approving paper compliance for a revisit. What corrective action(s) will be	08/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Austin Smith	Executive Director, HFA	08/19/2024

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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	Findings include: During an interview on 8/5/24 at 9:57 AM, the Administrator indicated on 5/18/24 Resident B was in the courtyard with Activity Aide 2. Activity Aide 2 told Resident B she needed to use the restroom and indicated for Resident B to stay in the courtyard. Activity Aide 2 returned from the restroom and Resident B was no longer in the courtyard. The Administrator indicated Resident B had exited the courtyard through the gate, walked around the building to door 8 and rang the door bell. The Administrator indicated Resident B was let in by staff and Resident B's nurse was notified. The Administrator indicated the gate exiting the courtyard was not locked. During an interview on 8/5/24 at 10:30 AM, the Director of Nursing (DON) indicated on 5/18/24, Activity Aide 2 entered the courtyard with Resident B. The DON indicated Resident B had a wanderguard/code alert attached to her walker. The DON indicated the door to the courtyard alarmed due to Resident B's wanderguard/code alert. Activity Aide 2 disarmed upon entering the courtyard. The gate did not have a code alert alarm. A statement, undated, was provided by Human Resources on 8/5/24 at 10:03 AM. The statement indicated the Activity Aide 2 did not realize Resident B shouldn't be unattended outside. The typical standard was to not leave residents outside alone. Resident B was able to walk herself, communicate her needs/wants and was alert. The statement indicated activity staff were given education regarding residents not to be outside alone when the following applied: the resident was a fall risk, unable to communicate needs/wants, confusion, dementia, and/or the		accomplished for those residents found to have been affected by the deficient practice; 1. Immediately following the incident on 5/18/24, Resident B was assessed for any injuries or distress and none were found. 2. Resident B's care plan was reviewed and updated to include enhanced supervision protocols when in the courtyard or other unsecured areas. 3. Activity Aide 2 and was immediately re-educated on elopement protocols, specifically the requirement to never leave a resident unattended in unsecured areas. 4. On 7/19/24, after review from the interdisciplinary team and discussions with the resident's family it was decided to move the resident to the facility's secured memory care unit. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 1. On 5/20/24, a list of residents that could be left on patio alone was compiled and given to nursing and activities staff. Exhibit 1. After this initial review, residents will continue to be reviewed quarterly for wandering or risk for elopement and as needed based	

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	resident is unable to move/transfer themselves. During an interview on 8/15/24 at 11:30 AM, Registered Nurse (RN) 3 indicated cognitively intact residents were allowed to be on the patio/courtyard area unattended. Residents who were unable to be alone, staff stayed with the residents while in the courtyard. RN 3 indicated Resident B had a wanderguard/code alert on her walker due to exit seeking. A record review was completed on 8/5/24 at 10:56 AM. Diagnosis include dementia and anxiety disorder. A progress note, dated 5/18/24, indicated around 3:20 PM, Resident B was outside, on patio with Activity Aide 2. Activity Aide 2 went inside to use the restroom and left Resident B outside, unattended on the patio. While unattended Resident B opened the gate, walked around the building to door 8 and rang the doorbell. A nurse let Resident B inside and called Resident B's nurse to assist resident back to the hall she resided on. The progress note also indicated Resident B's mental state was normally confused. A policy, revised 3/22, titled "Elopement of a Resident," was provided by Human Resources on 8/5/24 at 10:03 AM. The policy indicated "elopement is defined as an unplanned exit of a resident outside of the building..educate all staff to "at risk" status and interventions developed to reduce or prevent elopement." This Federal citation relates to Complaint IN00434869. 3.1-45(a)		on need. 2. On 5/20/24, frequent patio checks were implemented by nursing, Exhibit 2. This continued until the code alert on the patio gate was installed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; 1. On 6/28/2024, a code alert was added to the patio gate where the elopement occurred. This will notify the facility if a resident with a code alert passes through the gate until silenced by a team member who knows the code. Exhibit 3. 2. A staff member will maintain the list of residents who can be left on the patio alone. 3. Elopement training will be added to new hire training, must be completed within 90 days of hire, Exhibit 4. 4. Mandatory in-service training for all staff on our elopement policy was completed on 6/3/2024, Exhibit 5. 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; and 1. The DON will report the list of residents who can be left alone on	

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			the patio in the monthly QAPI meetings and to the Administrator to ensure that it is being updated in a timely manner. After 6 months of review, the QAPI team will determine if the monthly review can be stopped or must continue if based on deficient findings. 2. Weekly audits of the courtyard gate and other exits will be conducted for 6 months to ensure compliance with security measures.	