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	04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD GREENWOOD, IN 46143

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00405175. Complaint IN00405175 - State deficiencies related to the allegations are cited at R0052. Survey date: April 10, 2023 Facility number: 014079 Residential Census: 59 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April 14, 2023.	R 0000	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance.	
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 neglected to prevent a resident from exiting the facility without supervision for 1 of 3 residents reviewed for elopement. This resulted in a resident exiting the facility through a window two times. (Resident B) Finding includes:	R 0052	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The	06/05/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erin Marie Beiriger	Executive Director RCA	04/27/2023

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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	During an interview on 4/10/23 at 9:07 a.m., the Administrator indicated the facility was able to piece together what happened when Resident B exited the facility. The first time, on 3/27/23, staff observed Resident B go to the exit doors and forcefully push against the doors. The staff tried to calm him down and walked him to the nurse's station. At that time, Resident B seemed to have calmed down, so staff asked him to go back to his room to get ready for a shower. Resident B started walking back to his room. Resident B's family had just arrived to sit with him due to his exit seeking behaviors. The staff informed the family that Resident B had walked to his room. When the family got to his room, Resident B was not in his room. Facility staff began searching and called 911. A staff member coming in to work saw him trying to cross the street in front of the facility. The family had already started looking in their car. Staff walked outside to look, and he was sitting in a neighbors garage talking to the home owner. The paramedics nor the police had arrived yet, so Resident B's family took him to the hospital in their private car. The total time from noticing he was not in his room until he was located was approximately 15 minutes. Resident B had exited the building through his window. Resident B was moved to a room with a window that opened to the courtyard and placed on 1-1 supervision. The second time Resident B exited the facility, on 4/7/23, he went across the hall to another resident's room and climbed out her window. A staff member noticed that the resident's window was open, and the screen was removed. Staff immediately looked out the window and saw Resident B standing by the dumpster. Staff immediately went outside to get Resident B to come back inside, but he was not easily redirected until a staff member with a wheelchair asked him		preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance. Plan of Correction: R0052/Survey ID Z4TJ11 · What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? o The affected resident was moved to a courtyard-facing apartment and is required to have a 1:1 caregiver 24/7 to maintain safety within the Community's secured unit. Care conferencing and consistent communications between the Community's Memory Care Director, the Community's Wellness Director, and the resident's family are in place to provide updates, monitor behavior changes, and make adjustments as needed for resident success. Resident has recently had an evaluation with a Geriatric Psychiatrist, and the Resident's PCP added a medication to assist with mood stabilization. Additionally, the Community's Executive Director, Community's Maintenance Supervisor, Wellness Director, and	

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	to come inside with her and he nicely agreed. Resident B had a laceration on his forehead. The clinical record for Resident B was reviewed on 4/10/23 at 8:32 a.m. The diagnoses included, but were not limited to, dementia and mood disorder. A service plan, dated 4/1/23, indicated Resident B eloped on 3/27/23 and 4/7/23. Interventions included, but were not limited to, Room move, resident bedroom window is now by enclosed courtyard, and 1:1 provided by CNA at all times. A progress note, dated 3/27/23 at 7:21 p.m., indicated Resident B was observed in the lounge area by staff. Resident B was having behaviors (threatening staff, going in and out of rooms). Writer placed call to family for 1:1 intervention, Resident B's family stated she would be at facility shortly. Resident B was observed by staff wandering and pacing. Resident B was last seen headed towards his room. Family arrived 10-15 minutes after phone call was placed. Daughter came to nurses station and asked what happened and where Resident B was. Writer told family he was headed towards his room 5 minutes prior. Family came out of the room and stated he was not in the room. Writer immediately activated elopement search per protocol. Staff began to search for resident inside facility and outside of facility. Family stated they were calling 911, no officer arrived, management was notified during search. Family left premises stated they found resident, didn't tell staff location of where he was found. Stated he was headed to the hospital with family. A progress note, dated 3/27/23 at 10:54 p.m., indicated Resident B returned with family from		Memory Care Director have been involved in conversations and research on how to ensure resident safety from elopements with Pella Window manufacturer, local Fire Marshall, Fire Captain and Fire Chief, IDOH Area Supervisor, ESL Regional Operations Team, combined with state regulations, resident rights, and fire safety code to find a common ground for the safety and well-being of this and all residents. Interviews with other local assisted living and memory care facilities have been conducted to determine processes other communities are following to safely secure residents without hindering resident rights. In lieu of paying for the full-time 1:1 caregiver, the family has decided to move the resident from our community by 5/1/23, as paying for monthly expenses in addition to the 1:1 caregiver will be cost prohibitive. · 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? o Follow up evaluations and increased rounding, monitoring is being done with the residents in the memory care facility. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice	

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	hospital. No new orders, follow up needed with primary physician. Resident had laceration on left above eye area, bruise on left elbow area. Resident was in room with 1:1 intervention throughout night, with 15 minute checks initiated. Resident is in bed resting with unlabored breathing and respirations. A progress note, dated 3/28/23 at 7:27 p.m., indicated Resident B opened the window and stuck his head out and yelled for help. Resident B was asked to close the window. Resident B was resistant to and required staff of 4 to distract and assist. DON and daughter informed of current situation. Resident B remains on 1:1. Resident B is currently sitting in a wheelchair at the nurses' station. A progress note, dated 4/7/23 at 6:30 p.m., indicated writer entered unit at 6:30 P.M. CNA stated, has anyone seen Resident B located in Room 16. Another CNA stated I saw him by Room 25. Staff immediately went to Room 25, writer open door and notice window was ajar, and the screen was removed. Resident B's back brace was on the floor. Elopement protocol was initiated, and staff immediately ran outside to located resident. Staff started yelling out resident name when children that were outside playing stated he's over here. The CNA walked over to the house next door to facility and found resident in the garage with home owners. Resident B was assisted back to facility by staff. Upon arrival writer noticed abrasion to mid back of head and left knee. Resident B stated he hit his head. 911 was dispatched to transport resident to hospital for evaluation and treatment due to a head injury. Power of Attorney, Director of Nursing were notified via phone, the doctor was notified via fax. The Executive Director was present. Vital signs		does not recur? o In collaboration with the window manufacturer, fire Marshall, our ESL Regional Operations Team, the state regulations and resident rights, Demaree Crossing has purchased window sensor alarms that will sound in the event that the window opens. These window sensor alarms will be installed after delivery and will be complete by 5/5/23 at the latest. This device will allow the team to check on and ensure resident safety. Since the first elopement on 3/27/23, we have focused training staff by department and improving accountability on elopement procedures, rounding the building and resident room checks. Additionally, we have implemented a new resident health and safety watch tool that is available for all staff to report any resident changes they notice. The Executive Director, Wellness Director and Memory Care Director started holding weekly wellness IDT meetings on 4/13/23 to discuss incidents, resident changes, care conferences, meet with outside service providers, and provide intervention solutions for resident safety needs. · How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?	

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	were blood pressure 129/81, pulse 109, temperature 97.0, respirations 16, pulse ox 95% on room air. On 4/10/23 at 11:00 a.m., the Administrator provided a copy of a facility policy, titled Elopement Reduction Plan, dated 12/27/21, and indicated this was the current policy used by the facility. A review of the policy indicated residents at risk for potential elopement will be identified, and efforts to reduce risk of elopement through personalized interventions will be implemented. This State tag relates to Complaint IN00405175.		o Weekly Wellness IDT Meetings are completed every Tuesday at 1pm with key leaders, notes and care plans have been updated in PCC, maintenance security checks will be completed on the alarm sensory monitors monthly for 6 months and then semiannually thereafter. Staff training on elopements, rounding, and room checks will continue monthly. · By what date the systemic changes will be complete? 6/5/23	