| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155215 | A. Building<br>B. Wing | 03/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Plainfield Health Care Center | 3700 Clarks Creek Rd<br>Plainfield, IN 46168 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34129<br><br>Based on interview and record review, the facility failed to ensure a resident's elopement incident was accurately reported after the resident exited an open window on the second floor sunroom and the resident sustained injuries for 1 of 3 incidents reviewed for accuracy (Resident B).<br><br>Findings include:<br><br>An Indiana State Department of Health Survey System report, dated 3/16/24 at 8:40 p.m., submitted by the facility indicated Resident B had exited the second story of the facility through a window. Resident B unlocked the safety latch of the window and utilized a gait belt tied/anchored to a sitting chair to lower herself to the ground. Resident B was observed in the parking lot by Licensed Practical Nurse (LPN) 5. LPN 5 informed onsite staff and initiated the elopement protocol; visual line of sight was never broken. The resident had refused an assessment and treatment by facility staff and was extremely combative. Resident B made multiple attempts at physical contact towards staff. The resident was transferred and admitted to a local hospital, and no injuries were known.<br><br>On 3/19/24 at 12:58 p.m., Resident B's family indicated they did not know too much about the incident. Resident B told the family she had been pushed out the window. The facility had contacted Resident B's family and indicated the resident had tied a gait belt to a chair, climbed out of the window on the second story sunroom porch and fell on a car below. The resident's hand was bleeding, and she was transported to the hospital. Resident B had multiple injuries which included fractured vertebrae, fractured pelvis, 2 fractures in the right foot and a fractured left foot with possible surgery needed. The hospital was still completing assessments on Resident B. The family had noticed a small scratch on the resident's right hand. Prior to admission to the facility, Resident B lived in an assisted living facility and Resident B had not exhibited exit seeking behaviors because she could go outside. Resident B had vision deficits and dementia, when living in the AL facility and the family felt that Resident B would be safer residing in a secured memory care unit. They believed they were putting her somewhere where she would be safe and 36 hours later she was injured. Resident B kept telling the family that she was pushed by 3 waitresses out the window and believed she was a waitress also. The family had questioned the facility on how and why the incident had happened and if anyone had seen the resident go out the window.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A local hospital (ED) Emergency Department report, dated 3/16/24 at 9: 35 p.m., indicated Resident B, a [AGE] year-old female, with a diagnosis of Alzheimer's disease, resided at (assisted living facility name), was found down in the parking lot and it was assumed that she jumped versus possible fall from the second floor window and crawled to the parking lot. The fall was not witnessed. The time of the fall was unknown time and the resident's level of consciousness after the fall was unknown. Diagnoses and Plan indicated Resident B had a burst fracture of T12 vertebral body, transverse sacral fracture at S2-S3 vertebrae with suspected bilateral neural foraminal involvement, fracture of the left calcaneal body with a left ankle deformity and diffuse pain down spine.<br><br>A record review was completed for Resident B, on 3/19/24 at 2:00 p.m. Diagnosis upon admission 3/15/24, included but was not limited to Alzheimer's dementia disease.<br><br>A progress note, dated 3/16/2024 at 8:29 p.m., indicated around 8:30 p.m., LPN 6 was coming up the 500 hall after helping another resident and heard LPN 5 yell out, the porch window was opened and Resident B was gone. LPN 6 yelled for Certified Nursing Aide (CNA) 7 and CNA 8 to help find Resident B. LPN 6 ran outside with CNA 8 right behind. When LPN 6 got outside she immediately looked to the left, towards the opened window. LPN 6 saw Resident B crawling on her hands and knees on the gravel between the car and the building right under the window. Resident B was dragging a pillow with her. LPN 6 and CNA 8 immediately approached Resident B and tried to assist her. They told Resident B to stay still in case she was hurt from the fall. Resident B refused to let them or anyone get close to her and hit them with the pillow. LPN 6 did not see any obvious signs of injury. The resident was not complaining of any pain. She was yelling at everyone, Get away from me, leave me alone, I am only 10 minutes away from the apartment. LPN 6 called 911 at 8:39 p.m. and we stayed with the resident as Resident B continued to crawl up the grass hill. Resident B continued to refuse to let anyone get near her or help her. She continued to violently swing with the pillow at anyone that got too close to her. Resident B tried to stand up a few times and would get to her feet and then fall back down on the grass. Again, they attempted to help her and again she refused. The resident did not complain of any pain, and we never saw any blood other than the drops on the pillow. Resident B continued to crawl up the hill yelling the whole way until EMS (emergency medical services) arrived. When EMS arrived, the resident had crawled all the way up the hill to the front parking lot. When EMS approached her, she laid down flat on her back and started telling them that we would not let her out and locked her up there. EMS asked Resident B if she had jumped out the window and she told them yes, because we would not let her get to the apartment that was 10 minutes away. She did not complain of pain until EMS asked and she told them her left foot was hurt.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/19/24 at 12:06 p.m., the Director of Nursing (DON) indicated Resident B never came back into the building after the incident. On 3/16/24 at 8:20 p.m., the resident was observed on the porch by staff. At 8:30 p.m., Licensed Practical Nurse (LPN) 5 did not see the resident nor hear anything and noticed the porch window wide open and saw the gait belt attached to a chair and hanging out the window. LPN 5 did not see anyone outside and had 2 Certified Nursing Assistances (CNA) and another nurse (LPN 6) look for Resident B. They went downstairs to the ground floor and outside to find the resident in the parking lot. LPN 6 observed the resident on the ground in the parking lot crawling, between a vehicle and the building. Resident B held a pillow with blood spots on it. The resident would not let staff near her and kept swinging the pillow at the staff, if they approached her, saying Get away from me! Staff stayed with her, while the resident crawled up on the grassy hill with staff following her and got to the edge of the parking lot, when the ambulance (EMS) arrived. The resident was happy to see EMS and cooperated with EMS. EMS did an evaluation of the resident, put a neck collar on the resident, placed the resident on the stretcher, and took the resident to the hospital. There were no obvious signs of where the blood came from that was on the pillow.<br><br>On 3/19/24, the facility indicated the gait belt Resident B tied to the chair inside the sunroom and placed over the window edge and out the window was measured to be two feet long. The facility indicated the distance from the window Resident B exited to the ground was measured to be a distance of 13 feet. The facility's investigation of the incident lacked documentation of evidence that Resident B lowered herself to the ground.<br><br>On 3/20/24 at 3:25 p.m. the area where the resident had been found on the paved parking lot and the grass area where the resident had crawled up to the front parking lot were observed with the ADM, DON, and LPN 6. The ADM indicated LPN 6 found the resident in the parking lot and stayed with her until EMS came to the facility. The ADM indicated the facility was unsure if the resident had any injuries since the resident had refused to let staff assess her. Despite Resident B indicating to EMS her foot was hurting and the facility staff seeing blood on the pillow, this information was not reported to the Indiana State Department of Health Survey System Report. The blood on the pillow could have come from anywhere.<br><br>During the exit conference on 3/22/24, the Administrator indicated the LPN that found Resident B outside, stayed with Resident B until EMS arrived. He indicated that was what he meant when he reported visual line of sight was never broken for Resident B. The report was filed before he had obtained the statements from the staff that worked that night and was a preliminary report. The ADM indicated the facility staff were unable to assess the resident and she did not inform facility staff she had injuries.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Indiana Department of Health Long-Term Care Abuse and Incident Reporting Policies and Procedure, dated 12/6/22, indicated .Purpose To facilitate compliance with state and federal law and regulation, as applicable, related to reporting of abuse and incidents in licensed long-term care facilities in Indiana . Definitions contained herein apply to comprehensive care facilities and/or licensed residential facilities as applicable .4. Elopement: Elopement occurs when a resident without decision making capacity leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so OR a resident with decision making capacity leaves the premises or a safe area, without facility knowledge, and does not return as per the resident plan of care or service plan, related to leaving the facility .14. Unusual occurrence: An unusual occurrence includes, but is not limited to .d. major accidents .Policy Statement Abuse and incidents will be reported and submitted to the Indiana Department of Health in compliance with federal regulations and/or state rules and this policy, as applicable .Procedures and Responsibilities INSTRUCTIONS FOR SUBMITTING AN INCIDENT REPORT . B. Information to include in the report: Note: Initial and follow-up report can be submitted together if all necessary information has been obtained within the timeframe for initial reporting .1. Initial report should include: .f. Brief description of event g. Type of injury(s) sustained<br><br>This citation relates to Complaint IN00430651.<br><br>3.1-28(c) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34129<br><br>Based on observation, interview, and record review, the facility failed to provide effective supervision to prevent a cognitively impaired resident from exiting the second story locked memory care unit through an open window located approximately 13 feet above the ground by using a gait belt and failed to conduct an elopement assessment when the cognitively impaired resident verbalized the intention to elope from the facility for 1 of 3 residents reviewed for accidents. Resident B sustained a fractured left heel, a fractured left ankle, two fractures of the sacral vertebras, and a thoracic vertebra fracture (Resident B).<br><br>The immediate jeopardy began on 3/16/24 when a cognitively impaired resident with a diagnosis of Alzheimer's, who was admitted on e day before to the locked memory care unit, was observed with exit seeking behaviors throughout the day on 3/16/24. Resident B was observed to attempt to leave the unit, opening a window on the unit's second story porch, taking her belongings to the porch, and asking to leave the facility. On 3/16/24 at 8:30 p.m. staff observed an opened window on the unit's sunroom [ROOM NUMBER] feet above ground with a 2 foot gait belt hanging out the window. The gait belt was tied to a chair next to the window and Resident B was missing. Resident B was found outside crawling in the parking lot and holding a pillow with blood on it. ER documentation indicated Resident B's left foot was deformed and she complained of back pain. She was diagnosed with a fracture of the left calcaneal (heel), fracture of the left malleolus (ankle), fracture of two sacral vertebras (S2 and S3), and a burst thoracic spine vertebra at T12. The Administrator (ADM) was notified of the immediate jeopardy at 5:01 p.m. on 3/20/24. The immediate jeopardy was removed on 3/21/24, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>An Indiana State Department of Health Survey System report, dated 3/16/24 at 8:40 p.m., indicated Resident B had exited the second story of the facility through a window. Resident B unlocked the safety latch of the window and utilized a gait belt tied/anchored to a sitting chair to lower herself to the ground. Resident B was observed in the parking lot by Licensed Practical Nurse (LPN) 5. LPN 5 informed onsite staff and initiated the elopement protocol. The report indicated that visual line of sight of the resident was never broken. The resident had refused an assessment and treatment by facility staff and was extremely combative. Resident B made multiple attempts of physical contact towards staff. The resident was transferred and admitted to a local hospital, no injuries were known. The report did not include sufficient documentation to indicate the facility provided effective supervision to prevent the resident from exiting the facility through an open, unsecured second story window.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/19/24 at 12:58 p.m., Resident B's family indicated they did not know too much about what happened on 3/16/24, but the family feared the resident would not survive the injuries from the fall. Resident B told the family she had been pushed out the window. The facility had contacted Resident B's family and indicated the resident had tied a gait belt to a chair, climbed out of the window on the second story sunroom and fell on a car below. The resident's hand was bleeding, and she was transported to the hospital. Resident B had multiple injuries which included fractured vertebra, fractured pelvis, 2 fractures in the right foot, and a fractured left foot with possible required surgery. The hospital was still completing assessments on her. The family had noticed a small scratch on the resident's right hand. When she resided in the assisted living (AL) facility prior to the admission to the skilled nursing facility, Resident B had not exhibited exit seeking behaviors, because she could go outside as she wished. Resident B had vision deficits and dementia, so the AL facility and the family felt that Resident B would be safer residing in a secured memory care unit. The family thought they were putting her somewhere where she would be safe and 36 hours later she was injured. Resident B kept telling the family that she was pushed by 3 waitresses out the window and believed she was a waitress also. The resident believed she had a job at the facility as a waitress. The family had questioned the facility, of how and why the incident had happened, and did anyone see the resident go out the window.<br><br>A local hospital Emergency Department (ED) report, dated 3/16/24 at 9:35 p.m., indicated Resident B, a [AGE] year old, female with a diagnosis of Alzheimer's disease, who resided at a (former Assisted Living facility name) center was found down in the parking lot. It was assumed that she jumped versus a possible fall from the second floor window and crawled to the parking lot. The fall was not witnessed and unknown time of fall or level of consciousness. Diagnoses and Plan indicated Resident B had a burst fracture of the thoracic T12 vertebral body, transverse sacral fracture at S2-S3 with suspected bilateral neural foraminal involvement, fracture of the left calcaneal body with a left ankle deformity and diffuse pain down the spine.<br><br>On 3/19/24 at 11:00 a.m., the Administrator (ADM) provided pictures of the gait belt tied to the chair, the manufacturer window latch, and manufacturer safeguard spring-loaded window guard which prevented the window from being raised more than a few inches on the sunroom windows.<br><br>A record review was completed for Resident B on 3/19/24 at 2:00 p.m. Diagnosis upon admission on 3/15/24, included but was not limited to Alzheimer's dementia disease.<br><br>An Admission Evaluation record for Resident B, dated 3/15/24 at 12:14 p.m., indicated the resident was alert and oriented to person and situation, and ambulated without assistance. The assessment lacked documentation the resident wandered or had exit seeking behaviors.<br><br>A progress note, dated 3/16/2024 at 9:43 a.m., indicated the resident was saying she did not live at the facility and that she was trying to go home. The progress note lacked documentation of assessing the resident's risk for elopement.<br><br>A progress note, dated 3/16/2024 at 10:35 a.m., indicated the resident was upset and the charge nurse came to talk to her and called her granddaughter to calm her down. This only worked for a little while and the resident continued to wander. The progress note lacked documentation assessing the resident's risk for elopement or additional interventions attempted.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A late entry progress note, created by LPN 11, on 3/17/24 at 10:38 a.m., with effective date of 3/16/24 at 10:24 a.m., indicated on 3/16/2024 at 10:40 a.m., Resident B was standing against the wall with her arms crossed and her jacket in her hand at the end of the 400 hallway by the locked door. Resident B was not pushing on the door or touching the door but was standing near it. Resident stated, as soon as this door opens, I have to get out of here and get to my apartment that's 10 minutes away to feed my dog. LPN 11 informed the resident that those doors did not open and asked if the resident would like to call someone to make sure her dog was getting fed. Resident agreed and walked with the nurse to the 400 hallway nurses' station to the facility phone. The progress note lacked documentation of assessing the resident's risk for elopement.<br><br>A progress note, dated 3/16/2024 at 1:11 p.m., indicated the resident was refusing lunch and continued to exit seek, nothing seemed to redirect her. The resident was stating that she had dogs dying at home and she would be calling 911. The resident continued to sit by the exit doors waiting for her ride. The progress note lacked documentation of assessing the resident's risk for elopement.<br><br>A progress note, dated 3/16/2024 at 1:21 p.m., indicated the resident's granddaughter arrived and asked about the resident's day. The nurse informed her of the resident being anxious, exit seeking and upset about being at the facility. The granddaughter decided to leave due to the fact that she felt her presence would make the situation worse, so she stated that her sister would come visit 3/17/24. The progress note lacked documentation of assessing the resident's risk for elopement.<br><br>A progress note, dated 3/16/2024 at 5:30 p.m., indicated the resident ate dinner on the sunroom porch stating that she would only eat if staff allowed her to eat there. The resident ate her meal and wandered around some more but was okay. The progress note lacked documentation of assessing the resident's risk for elopement.<br><br>A progress note, dated 3/16/2024 at 7:45 p.m., created by LPN 6 indicated this nurse was informed by another resident's family member that Resident B had opened a window on the porch. An aide got to the window before LPN 6 and told LPN 6 that the window only opened a few inches. LPN 6 also confirmed that the window did not open fully. LPN 6 had been assisting another resident with eating supper at the time, so she continued assisting the other resident. The progress note lacked documentation of assessing the resident's risk for elopement.<br><br>A progress note, dated 3/16/2024 at 7:45 p.m., indicated while assisting another resident with her medications the nurse was informed by a coworker that the resident was witnessed sitting on the ground on the sunroom porch and had laid down. The nurse stated that she looked like she was trying to fall asleep. Once the nurse finished giving the medication and assisting the other resident, she went into the sunroom. At the time the resident was sitting on the chair, and the nurse asked Resident B if she wanted to watch a movie with other residents. Resident B started to explain that her dogs were not being fed at home and how they would die. The nurse told the resident she would see what she could do. The nurse started the movie for the other residents in the main area and was getting things together so that she could start charting. She heard one of the high fall risk patients and saw him down the hall walking. The nurse grabbed the aide for her assistance, and they went down the 500 hall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A progress note, dated 3/16/2024 at 8:29 p.m., indicated LPN 6 was coming up the 500 hall after helping another resident and heard LPN 5 yell out that the porch window was open, and Resident B was gone. LPN 6 yelled for Certified Nursing Aide (CNA) 7 and CNA 8 to help find Resident B. LPN 6 ran outside with CNA 8 right behind. When LPN 6 got outside she immediately looked to the left, towards the opened window. LPN 6 saw Resident B crawling on her hands and knees on the gravel between the car and the building right under the window. Resident B was dragging a pillow with her. LPN 6 and CNA 8 immediately approached Resident B and tried to assist her. We told her to stay still in case she was hurt from the fall. Resident B refused to let anyone get close to her and was hitting staff with the pillow. LPN 6 did not see any obvious signs of injury. The resident was not complaining of any pain. She was yelling at everyone, Get away from me, leave me alone, I am only 10 minutes away from the apartment. LPN 6 called 911 at 8:39 p.m. and stayed with the resident as Resident B continued to crawl up the grass hill. Resident B continued to refuse to let anyone get near her or help her. She continued to violently swing with the pillow at anyone that got too close to her. Resident B tried to stand up a few times and would get to her feet and then fall back down on the grass. Again, staff attempted to help her and again she refused. The resident did not complain of any pain, and staff never saw any blood other than the drops on the pillow. Resident B continued to crawl up the hill yelling at us the whole way until EMS (emergency medical services) arrived. When EMS arrived, the resident had crawled all the way up the hill to the parking lot. When EMS approached her, she laid down flat on her back and started telling them that we would not let her out and locked her up there. EMS asked Resident B if she had jumped out the window and she told them yes, because we would not let her get to the apartment that was 10 minutes away. She did not complain of pain until EMS asked and she told them her left foot was hurt.<br><br>The resident's record lacked documentation of a physician's order to reside in a secured memory care unit, a wandering/elopement assessment, a baseline care plan to indicate the resident had wandering and exit seeking behaviors had been completed at the time of the resident's elopement on 3/16/24.<br><br>The resident's medical record lacked documentation of pre-admission screening. The documentation was requested from management and was not provided during the survey process.<br><br>On 3/19/24 at 8:50 a.m., the Administrator (ADM) indicated the family of Resident B had contacted him about the incident of Resident B exiting through the window and had cussed him out and threatened to contact the news media about the event. Since the incident, the memory care unit porch windows had been secured and reinforced with steel brackets, catch plates and window alarms.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/19/24 at 12:06 p.m., the Director of Nursing (DON) indicated Resident B never came back into the building after the incident. On 3/16/24 at 8:20 p.m., the resident was observed on the porch by staff. At 8:30 p.m., Licensed Practical Nurse (LPN) 5 did not see the resident nor hear anything but noticed the porch window wide open and saw the gait belt attached to a chair and hanging out the window. LPN 5 did not see anyone outside and had 2 CNAs and another nurse (LPN 6) look for Resident B. They went downstairs to the ground floor and outside to find the resident in the parking lot. LPN 6 observed the resident on the ground in the parking lot crawling, between a vehicle and the building. Resident B held a pillow with blood spots on it. The resident would not let staff near her and kept swinging the pillow at the staff, if they approached her, saying Get away from me! Staff stayed with her, while the resident crawled up on the grassy hill with staff following her and got to the edge of the parking lot, when the ambulance (EMS) arrived. The resident was happy to see EMS and willing to cooperate with EMS. EMS did an evaluation of the resident, put a neck collar on the resident, placed the resident on the stretcher, and took the resident to the hospital. The sunroom porch used to be open for all the residents. The alarm was placed on the porch door after the incident, the same night. There were no obvious signs of where the blood came from that was on the pillow.<br><br>On 3/20/24 at 8:55 a.m., DON indicated there was no damage to the vehicle parked next to the building in the parking lot. They were unsure where the resident landed from the window. The old window safety latches were still on the windows, but with the newly installed window brackets, the windows could not be opened more than a few inches. They developed an elopement care plan, dated 3/19/24, when LPN 6 completed the elopement assessment and signed it on 3/19/24.<br><br>On 3/20/24 at 2:43 p.m. LPN 6 indicated on 3/16/24 she was providing care in the memory care unit and was assigned Resident B. Prior to the resident going out the window, Resident B had indicated to LPN 6 that she needed to go home to feed her pet and was sitting on a chair in the porch. LPN 6 asked her to watch a movie and Resident B indicated she wanted to go home. Another resident was calling for staff and LPN 6 went down the hall with the other resident to help. LPN 5 called out from the porch and indicated the porch window was open and she did not see Resident B. LPN 6 went down the stairs and outside and observed Resident B on the blacktop driveway on her hands and knees. LPN 6 came towards the resident and told Resident B that she needed to check her out. Resident B was holding a pillow and swinging the pillow at the LPN. The pillow had drops of blood on it. The closer she got to the resident; the resident would crawl away. The resident tried to stand twice and fell down. At 8:39 p.m., LPN 6 was dialing 911 from her cell phone to get assistance. There were 2 CNAs with the LPN and the resident in the parking lot. The resident crawled up the grassy area to the front parking lot when EMS arrived. When EMS arrived, the resident told EMS that the three ladies would not let her leave and go home. EMS assessed the resident, and asked if she had any pain. Resident B replied that her left ankle was hurting. The resident was placed on a stretcher and was sent to the hospital. The resident was easily redirectable and was not showing aggressive behaviors with EMS. It was dark on the sunroom porch without any lights on and dark outside. Resident B was found by the car on the passenger side by the tire in the parking lot.<br><br>On 3/20/24 at 3:25 p.m. the area where the resident had landed on the paved parking lot and grass area where resident had crawled up to the front parking lot were observed with the ADM, DON, and LPN 6. The ADM indicated LPN 6 found the resident in the parking lot and stayed with her until EMS came to the facility.<br><br>On 3/21/24 at 8:45 a.m., DON indicated ideally, the staff should have notified her when the resident had opened the sunroom window the first time and had displayed exit seeking behaviors.<br><br>(continued on next page) |

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| | 155215 | A. Building<br>B. Wing | 03/22/2024 |

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| Plainfield Health Care Center | 3700 Clarks Creek Rd<br>Plainfield, IN 46168 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/21/24 at 9:53 a.m., Certified Nursing Aide (CNA) 9 indicated she met the resident on 3/16/24 at 3 p.m. at the beginning of her shift on the secured memory care unit. CNA 9 was not told why the resident was on the secured wing. She did not help the resident much except to talk with her. The resident was particularly upset at someone, wanting to go home, was suspicious of staff, and would spout profanities at them. Resident B seemed to be higher functioning than most residents on the unit and walked around the unit looking at windows and doors trying to find a way out which got the other residents upset, and asked for the train or bus to leave. Resident B would at times have a garment or personal item in her arms as she walked a lot around the unit. CNA 9 was not successful offering diversions, and the resident would say you're on her side. The resident worried about her animals. CNA 9 indicated she usually could divert a resident by offering to introduce to a friend. Resident B was not diverting with this technique. Around 5:00 - 5:30 p.m. as the residents were getting ready for supper, a family member alerted CNA 9 to the fact Resident B had opened a window a few inches on the porch. CNA 9 jerked the window up roughly a few times and it would only open a few inches. The front half of porch windows did not open, only a few side windows would open for ventilation. CNA 9 understood Resident B had been told that she was just staying for one night and was brought to the facility by a family member, but the next morning, when the resident realized she was not going home she became very upset. The resident had spent most of the evening on the porch, which was not unusual as the residents thought there was an exit door out there. There was a ceiling light on the porch, but after the resident had been taken to the hospital, CNA 9 tried the light switch, and the light would not turn on. There was a light in the parking lot, but CNA 9 did not see the resident in the parking lot as the resident had already crawled off. At the time the resident was found outside around 8:34 p.m., CNA 9 had been out taking out the trash, and co-worker CNA 7 had called and said Resident B was out. CNA 9 was in the back of the building taking trash to the dumpster, not near the side of the facility where the resident had got out on the parking lot, immediately CNA 9 came back inside the building. When she got back inside, CNA 7, CNA 8, and LPN 6 were outside with the resident, and LPN 5 was inside. LPN 5 asked CNA 9 if she would watch the unit so LPN 5 could go outside and help the resident.<br><br>On 3/21/24 at 10:30 a.m., LPN 5 was observed working on the secured memory care unit and indicated she had worked on the unit full time since before covid. Resident B had been admitted to the facility Friday afternoon on 3/15/24 and LPN 5 met her on Saturday morning on 3/16/24. LPN 6 was the direct nurse for Resident B. The resident was observed to wander around the common areas. The resident would approach LPN 5 and asked her to unlock the doors, when told she could not, the resident usually walked off. Resident B did not like attempts to divert with activities and would walk off. Resident B was observed to go out onto the porch but was not observed attempting to open the windows.<br><br>On 3/20/24 at 2:30 p.m., the DON provided and identified a document as a current facility policy, titled Secure Care Neighborhood, dated 08/2020. The policy indicated, .The goal of the Secure Care Neighborhood is to meet the individual needs of residents with dementia related illnesses. The Secure Care Neighborhood will provide a safe environment that maximizes independence and provides an activity intensive atmosphere .The secure care neighborhood may be used to keep residents who are a high risk for elopement safe from exiting the facility. The resident should have an Elopement Risk Assessment completed with a physician order completed .The need for admission to the Secure Care Neighborhood must have a physician order .The resident must have a diagnosis of dementia related illness .The resident must be a high-risk wanderer<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The immediate jeopardy that began on 3/16/24 was removed 3/21/24 when the facility assessed all residents at risk for wandering and elopement, and if at risk, interventions were implemented and residents with current wandering and elopement risk were reviewed for appropriate care and interventions, and care plans updated. Nursing staff were in-serviced regarding residents with wandering and elopement behaviors. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring.<br><br>This citation relates to Complaint IN00430651.<br><br>3.1-45(a) |

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| F 0744<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34129<br><br>Based on observation, interview, and record review, the facility failed to provide individualized dementia care and supervision of a newly admitted resident with Alzheimer's dementia for 1 of 3 residents reviewed for dementia care (Resident B) which resulted in the resident exiting the locked memory care unit through a second story window approximately 13 feet above the ground and fracturing her left heel, left ankle, two sacral vertebrae, and a thoracic vertebra.<br><br>The immediate jeopardy began on 3/15/24 when a cognitively impaired resident with a diagnosis of Alzheimer's dementia was admitted to the nonsmoking locked memory care unit. Resident B was admitted from an assisted living facility, required minimal assistance with ADLs (Activities of Daily Living), and required no supervision when smoking cigarettes. Resident B was observed by facility staff to exhibit exit seeking behaviors throughout the day on 3/15/24 and 3/16/24. Resident B was observed to attempt to leave the unit, attempting to follow residents' family off the unit, and asking to leave the facility. Resident B refused her nicotine patch on 3/16/24 and indicated it did not work for her. On 3/16/24 at 8:30 p.m. staff observed a window on the unit's second story sunroom, that was 13 feet above ground level, was open and staff observed a 2 (two) foot gait belt was attached to a chair located in the interior of the facility and hanging out the window on the exterior of the building, the window and Resident B was missing. Resident B was found outside the facility below the open window in the parking lot. She was taken to the hospital and diagnosed with a fracture of the left calcaneal (heel), a fracture of the left malleolus (ankle), a fracture of two sacral vertebrae (S2 and S3), and a burst fracture of the thoracic spine vertebra at T12. The Administrator (ADM) was notified of the immediate jeopardy at 5:01 p.m. on 3/20/24. The immediate jeopardy was removed on 3/21/24, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview, on 3/19/24 at 12:58 p.m., Resident B's family indicated they did not know too much about what happened on 3/16/24, but the family feared the resident would not survive the injuries from the fall. Resident B told the family she had been pushed out the window. The facility had contacted Resident B's family and indicated the resident had tied a gait belt to a chair, climbed out of the window on the second story sunroom and fell on a car below. The resident's hand was bleeding, and she was transported to the hospital. Resident B had multiple injuries, fractured vertebra, fractured pelvis, fractured left foot and 2 fractures in the right foot with possible surgery on the left foot. The hospital was still completing assessments on her. The family had noticed a small scratch on the resident's right hand. When she resided in the assisted living (AL) facility prior to the admission to the skilled nursing facility, Resident B had not exhibited exit seeking behaviors, because she could go outside as she wished. Resident B had vision deficits and dementia, so the AL facility and the family felt that Resident B would be safer residing in a secured memory care unit. Resident B had aggressively grabbed her cell phone from staff when they were speaking to the family. We thought we were putting her somewhere where she would be safe and 36 hours later she was injured. Resident B kept telling the family that she was pushed by 3 waitresses out the window and believed she was a waitress also. The resident believed she gotten a job at the facility as a waitress. The family had questioned the facility, of how and why the incident had happened and did anyone see the resident go out the window.<br><br>An Indiana State Department of Health Survey System report, dated 3/16/24 at 8:40 p.m., indicated Resident B had exited the second story of the facility through a window. Resident B unlocked the safety latch of the window and utilized a gait belt tied to a chair to lower herself to the ground. Resident B was observed in the parking lot by Licensed Practical Nurse (LPN) 5. The resident refused to allow facility staff to perform an assessment or provide treatment and no injuries were identified. Resident B was extremely combative and made multiple attempts to make physical contact towards staff. The resident was transferred by EMS (Emergency Medical Services) and admitted to a local hospital.<br><br>Record review was completed for Resident B, on 3/19/24 at 2:00 p.m. Diagnosis upon admission to the facility on [DATE] included, but was not limited to, Alzheimer's dementia disease.<br><br>An Admission Evaluation record for Resident B, dated 3/15/24 at 12:14 p.m., indicated the resident was alert and oriented to person and situation and ambulated without assistance. The assessment lacked documentation that the resident wandered or had exit-seeking behaviors.<br><br>A progress note, dated 3/16/2024 at 9:43 a.m., indicated the resident was saying she did not live at the facility and that she was trying to go home. The resident refused her nicotine patch and was exit seeking. The progress note did not include documentation to show the facility provided effective treatment or services to ensure the cognitively impaired resident did not leave the facility unattended after the resident verbalized the intent to leave the facility.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A late entry progress note, created by LPN 11, on 3/17/24 at 10:38 a.m., with effective date of 3/16/24 at 10:24 a.m., indicated on 3/16/2024 at 10:40 a.m., Resident B was standing against the wall with her arms crossed and her jacket in her hand at the end of the 400 hallway by the locked door. Resident B was not pushing on the door or touching the door but was standing near it. LPN 11 approached the resident and asked if everything was ok. Resident stated, as soon as this door opens, I have to get out of here and get to my apartment that's 10 minutes away to feed my dog. LPN 11 informed the resident that those doors did not open and asked if the resident would like to call someone to make sure her dog was getting fed. Resident agreed and walked with the nurse to the 400 hallway nurses' station to the facility phone. The resident asked me to call her granddaughter. I looked up the granddaughter's phone number, dialed the number, and handed the phone to the resident. The granddaughter did not answer the phone at that time and the resident left a voicemail asking the granddaughter why she was not picking up the phone, why was she still here, and asked when she was getting picked up before she hung up the phone. LPN 11 asked the resident if she ate breakfast, and the resident told LPN 11 yes. LPN 11 asked the resident if she would like a cup of coffee and the resident said that would be great. Resident B walked with LPN 11 to the dining room area where she got the resident a cup of coffee. LPN 11 asked the resident where she would like to sit and drink her coffee. Resident B stated she preferred to go to her room and drink her coffee. LPN 11 walked with the resident back to her room and put her coffee into her personal thermal cup and asked if she needed anything else. Resident B said no and thanked the nurse for the cup of coffee. Resident B was sitting on her bed drinking her coffee with no signs or symptoms of agitation when the nurse exited the room. The progress note did not include documentation to show the facility provided effective treatment or services to ensure the cognitively impaired resident did not leave the facility unattended after the resident verbalized the intent to leave the facility.<br><br>A progress note, dated 3/16/2024 at 1:11 p.m., indicated the resident was refusing lunch and continued to exit seek, nothing redirected the resident. The resident was stating that she had dogs dying at home and she would be calling 911. The resident continued to sit by the exit doors waiting for her ride. The progress note did not include sufficient documentation to determine the interventions attempted by staff to re-direct the exit seeking behaviors and did not include documentation to show the facility provided effective treatment or services to ensure the cognitively impaired resident did not leave the facility unattended.<br><br>A progress note, dated 3/16/2024 at 1:21 p.m., indicated the resident's granddaughter arrived and asked about the resident's day. The nurse informed her of the resident being anxious, exit seeking and upset about being here. The granddaughter decided to leave due to the fact that she felt her presence would make the situation worse, so she stated that her sister would come visit tomorrow.<br><br>A progress note, dated 3/16/2024 at 5:30 p.m., indicated the resident ate dinner on the porch stating that she would only eat if staff allowed her to eat there. The resident ate her meal and wandered around some more but was okay.<br><br>A progress note, dated 3/16/2024 at 7:45 p.m., created by LPN 6 indicated, this nurse was informed by another resident's family member that Resident B had opened a window on the porch. An aide got to the window before LPN 6 and told LPN 6 that the window only opened a few inches. LPN 6 also confirmed that the window did not open that much. LPN 6 had been assisting another resident with eating supper at the time, so she continued assisting the other resident. The note lacked documentation Resident B was re-directed or had additional one to one continuous supervision by facility staff. The note lacked documentation on how LPN 6 confirmed the window did not open fully.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A progress note, dated 3/16/2024 at 7:45 p.m., indicated while assisting another resident with her medications the nurse was informed by a coworker that the resident was witnessed sitting on the ground on the sunroom porch and had laid down. The nurse stated that she looked like she was trying to fall asleep. Once the nurse finished giving the medication and assisting the other resident, she went into the sunroom. At the time the resident was sitting on the chair, and the nurse asked Resident B if she wanted to watch a movie with other residents. Resident B started to explain that her dogs were not being fed at home and how they would die. The nurse told the resident she would see what she could do. The nurse started the movie for the other residents in the main area and was getting things together so that she could start charting. She heard one of the high fall risk patients and saw him down the hall walking. The nurse grabbed the aide for her assistance, and they went down the 500 hall. The progress note lacked documentation to determine if additional interventions were attempted by staff to re-direct the exit-seeking behaviors.<br><br>Resident B's record lacked documentation of progress notes or any other documentation between 3/16/2024 at 7:45 p.m. through 3/16/2024 at 8:29 p.m. to show the facility provided effective treatment or services to ensure the cognitively impaired resident did not exit the second story of the facility through an open, unattended window.<br><br>A progress note, dated 3/16/2024 at 8:29 p.m., indicated LPN 6 was coming up the 500 hall after helping another resident and heard LPN 5 yell out that the porch window was opened and Resident B was gone. LPN 6 yelled for Certified Nursing Aide (CNA) 7 and CNA 8 to help find Resident B. LPN 6 ran outside with CNA 8 right behind. When LPN 6 got outside she immediately looked to the left, towards the opened window. LPN 6 saw Resident B crawling on her hands and knees on the gravel between the car and the building right under the window. Resident B was dragging a pillow with her. LPN 6 and CNA 8 immediately approached Resident B and tried to assist her. Resident B refused to let anyone get close to her and was hitting staff with the pillow. LPN 6 did not see any obvious signs of injury. The resident was not complaining of any pain. She was yelling at everyone, Get away from me, leave me alone, I am only 10 minutes away from the apartment. LPN 6 called 911 at 8:39 p.m. and staff stayed with the resident as Resident B continued to crawl up the grass hill. Resident B continued to refuse to let anyone get near her or help her. She continued to violently swing with the pillow at anyone that got too close to her. Resident B tried to stand up a few times and would get to her feet and then fall back down on the grass. The resident did not complain of any pain, and we never saw any blood other than the drops on the pillow. Resident B continued to crawl up the hill yelling at us the whole way until EMS arrived. When EMS arrived, the resident had crawled all the way up the hill to the parking lot. When EMS approached her, she laid down flat on her back and started telling them that staff would not let her out and locked her up there. EMS asked Resident B if she had jumped out the window and she told them yes, because staff would not let her get to the apartment that was 10 minutes away. She did not complain of pain until EMS asked and she told them her left foot was hurt.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The resident's record was reviewed to include physician orders, plan of care, baseline plans of care, assessments, events, progress notes, nursing notes, IDT notes, physician notes, admission notes, and scanned documents. Resident B's record lacked documentation of a physician's order to reside in a secured memory care unit, a wandering/elopement assessment, an admission minimum data set assessment, a care plan to indicate the resident had wandering and exit seeking behaviors had been completed at the time of the resident's elopement on 3/16/24. The resident record also lacked documentation additional interventions were put into place when the resident had made multiple statements she was going home, actions of opening the porch window, and holding the door open attempting to get out as visitors left the unit, and lacked documentation staff had notified the physician, Director of Nursing (DON), Administrator (ADM), nor a nurse manager of the resident's exit seeking behaviors. The resident's medical record lacked documentation of pre-admission screening. The pre-admission screening and any additional documentation not in the electronic medical record was requested from management throughout the survey and was not provided during the survey process or upon exit of the survey.<br><br>An Elopement Risk Evaluation form, signed and dated 3/19/24, (3 days after the resident eloped) LPN 6 documented Resident B was able to make decisions regarding tasks of daily living, e.g. decisions were consistent and reasonable. Resident was cognitively impaired and ambulated or propelled self. Patient may go outdoors on occasion but makes no attempt to leave grounds. The form indicated the resident ambulated and propelled herself, and or wandered, had made no attempt to leave the community, and had not verbalized a plan to elope from the community.<br><br>A local hospital Emergency Department (ED) report, dated 3/16/24 at 9:35 p.m., indicated Resident B, a [AGE] year-old female, with diagnosis of Alzheimer's disease, resided at a (former Assisted Living facility name) center was found down in the parking lot and assumed that she jumped versus possible fall from the second floor window and crawled to the parking lot. The fall was not witnessed and unknown time of fall or level of consciousness. Diagnoses and Plan indicated Resident B had a burst fracture of the thoracic T12 vertebral body, transverse sacral fracture at S2-S3 with suspected bilateral neural foraminal involvement, fracture of the left calcaneal body with a left ankle deformity and diffuse pain down the spine.<br><br>On 3/19/24 at 8:50 a.m., the Administrator (ADM) indicated the granddaughter of Resident B had contacted him about the incident of Resident B exiting through the porch window and had 'cussed' him out and threatened to contact the news media about the event. Since the incident, the memory care unit porch windows have been secured and reinforced with steel brackets, catch plates and window alarms.<br><br>On 3/19/24 at 12:06 p.m., the Director of Nursing (DON) indicated Resident B never came back into the building after the incident. On 3/16/24 at 8:20 p.m., the resident was observed on the porch by staff. At 8:30 p.m., Licensed Practical Nurse (LPN) 5 did not see the resident nor hear anything but noticed the porch window wide open and saw the gait belt attached to a chair and hanging out the window. LPN 5 did not see anyone outside and had 2 Certified Nursing Aides (CNA) and another nurse (LPN 6) look for Resident B. They went downstairs to the ground floor and outside to find the resident in the parking lot.<br><br>On 3/20/24 at 8:55 a.m., DON indicated they did not have an elopement care plan on 3/16/24. They developed an elopement care plan, dated 3/19/24, when LPN 6 completed the elopement assessment and signed it on 3/19/24.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/20/24 at 2:43 p.m. LPN 6 indicated on 3/16/24 she was providing care in the memory care unit and was assigned Resident B. Prior to the resident going out the window, Resident B had indicated to LPN 6 that she needed to go home to feed her pet and was sitting on a chair in the porch. LPN 6 asked her to watch a movie and Resident B indicated she wanted to go home. Another resident was calling for staff and LPN 6 went down the hall with the other resident to help. LPN 5 called out from the porch and indicated the porch window was open and she did not see Resident B. LPN 6 went down the stairs and outside and observed Resident B on the blacktop driveway on her hands and knees. It was dark on the sunroom porch without any lights on and dark outside. Resident B was found by the car on the passenger side by the tire in the parking lot.<br><br>On 3/21/24 at 8:45 a.m., DON indicated ideally, the staff should have notified her when the resident opened the sunroom window the first time and had displayed exit seeking behaviors. Unfortunately, staff did not inform DON on 3/16/24 of the resident's first time opening the window nor her exit-seeking behaviors.<br><br>On 3/21/24 at 9:53 a.m., Certified Nursing Aide (CNA) 9 indicated she met the resident on 3/16/24 at 3 p.m. at the beginning of her shift on the secured memory care unit. CNA 9 was not told why the resident was on the secured wing. She did not help the resident much except to talk with her. The resident was particularly upset at someone, wanting to go home, was suspicious of staff, and would spout profanities at them. Resident B seemed to be higher functioning than most residents to be on the unit and walked around the unit looking at windows and doors trying to find a way out, got the other residents upset, and asking for the train or bus to leave. Resident B would at times have a garment or personal item in her arms as she walked a lot around the unit. CNA 9 was not successful offering diversions, and the resident would say you're on her side. The resident worried about her animals. CNA 9 indicated she usually could divert a resident by offering to introduce to a friend. Resident B was not diverting with this technique. Around 5:00 - 5:30 p.m. as the residents were getting ready for supper, a family member alerted CNA 9 to the fact Resident B had opened a window a few inches on the porch. CNA 9 jerked the window up roughly a few times and it would only open a few inches. The front half of porch windows did not open, only a few side windows would open for ventilation. CNA 9 understood Resident B had been told that she was just staying for one night and was brought to the facility by a family member, but the next morning, when the resident realized she was not going home she became very upset. The resident had spent most of the evening on the porch, which was not unusual as the residents thought there was an exit door out there. There was a ceiling light on the porch, but after the resident had been taken to the hospital, CNA 9 tried the light switch, and the light would not turn on. There was a light in the parking lot, but CNA 9 did not see the resident in the parking lot as the resident had already crawled off. At the time the resident was found outside around 8:34 p.m., CNA 9 had been out taking out the trash, and co-worker CNA 7 had called and said Resident B was out. CNA 9 was in the back of the building taking trash to the dumpster, not near the side of the facility where the resident had got out on the parking lot, immediately CNA 9 came back inside the building. When she got back inside, CNA 7, CNA 8, and LPN 6 were outside with the resident, and LPN 5 was inside. LPN 5 asked CNA 9 if she would watch the unit so LPN 5 could go outside and help the resident. CNA 9 indicated she had been an aide for [AGE] years in this facility. She had not gotten all her training finished last year. She could not specifically remember having elopement/wandering training at this facility, it was just common sense. In her opinion, the secured memory care unit could use more staff members, 3 aides and 2 nurses were not enough eyes and hands, there was a lot to take care of that population and keep eyes on everyone.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155215 | A. Building<br>B. Wing | 03/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Plainfield Health Care Center | 3700 Clarks Creek Rd<br>Plainfield, IN 46168 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0744<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/21/24 at 10:30 a.m., LPN 5 was observed working on the secured memory care unit and indicated she had worked on the unit full time since before the COVID-19 pandemic. Resident B had been admitted to the facility, on Friday afternoon 3/15/24 and LPN 5 met her on Saturday morning on 3/16/24. She had no knowledge of why the resident was in the secured memory care unit. LPN 6 was the direct nurse for Resident B. The resident was observed to wander around the common areas. The resident would approach LPN 5 and asked her to unlock the doors, when told she could not, the resident usually walked off. Resident B did not like attempts to divert her behavior and would walk off. Resident B was observed to go out onto the porch but was not observed attempting to open the windows. LPN 5 indicated she had received on-going education electronically but did not specifically remember having wandering/elopement training.<br><br>On 3/21/24 at 10:45 a.m., the Memory Care Social Services (MSS) indicated she had worked at the facility for 7 years and as the MSS for about a year. The Interdisciplinary Team (IDT) made determination of who qualified to live on the secured memory care unit. Resident B had a dementia diagnosis, but MSS was not sure why the resident was admitted directly into a secured unit from assisted living versus being in general population at the facility. On 3/15/24 MSS was on the unit for about an hour after Resident B was admitted in the afternoon. Resident B was with her granddaughter in her room, eating donuts. She was unsure if the resident was okay with being admitted . MSS was not made aware on Saturday 3/16/24 of the resident wanting to go home and exit seeking. She was not notified that evening after the resident had eloped. Staff tried diversion if residents needed re-direction.<br><br>On 3/20/24 at 2:30 p.m., the DON provided and identified a document as a current facility policy, titled Secure Care Neighborhood, dated 08/2020. The policy indicated, .The goal of the Secure Care Neighborhood is to meet the individual needs of residents with dementia related illnesses. The Secure Care Neighborhood will provide a safe environment that maximizes independence and provides an activity intensive atmosphere .The secure care neighborhood may be used to keep residents who are a high risk for elopement safe from exiting the facility. The resident should have an Elopement Risk Assessment completed with a physician order completed .The need for admission to the Secure Care Neighborhood must have a physician order .The resident must have a diagnosis of dementia related illness .The resident must be a high-risk wanderer<br><br>The immediate jeopardy that began on 3/15/24 was removed 3/21/24 when the facility assessed all residents at risk for wandering and elopement, and if at risk, interventions were implemented and residents with current wandering and elopement risk were reviewed for appropriate care and interventions, and care plans updated. Nursing staff were in-serviced regarding residents with wandering and elopement behaviors. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring.<br><br>This citation relates to Complaint IN00430651.<br><br>3.1-37 |