STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sycamore Care Strategies	12802 East US Hwy 50 Loogootee, IN 47553

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent a resident who was at risk for elopement from leaving the facility property for 1 of 3 residents reviewed for accidents. (Resident C)This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on April 11, 2026, when the facility failed to provide adequate supervision to prevent Resident C from exiting the facility property at approximately 2:30 P.M. during an outdoor activity. Resident C was left on the front porch without staff supervision for approximately five minutes and located approximately 0.8 miles from the facility by a community bystander. The Facility Administrator was notified of the Immediate Jeopardy on 4/15/26 at 2:55 P.M. The Immediate Jeopardy was removed on 4/16/26 at 12:45 P.M., 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.Finding includes:On 4/15/26 at 10:30 A.M., an Indiana Department of Health (IDOH) Facility Reportable Incident (FRI) form, dated 4/11/26 at 2:33 P.M., indicated Resident C was unable to be located. Shortly after a search in and around the facility was completed, a neighbor of the facility arrived with the resident. During an observation on 4/15/26 at 11:05 A.M., Resident C was sitting in a recliner in a common area with a Wanderguard (device worn by a resident to prevent the resident from entering unsafe areas or leaving the facility) bracelet on her left ankle. A record review on 4/15/26 at 11:15 A.M., indicated Resident C's diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety. Resident C's most recent comprehensive admission Minimum Data Set (MDS) assessment, dated 8/25/25, indicated the resident's cognition was severely impaired, required supervision with walking up to 150 feet, and a wandering/elopement alarm device was used daily. Resident C's most recent Quarterly MDS assessment, dated 2/20/26, indicated the resident's cognition was severely impaired, was independent with walking up to 150 feet, and a wandering/elopement alarm device was used daily. An initial Risk for Elopement Assessment, dated 8/18/25, indicated Resident C was at risk for elopement due to wandering behavior, wandered aimlessly, the resident's wandering behavior was likely to affect the safety or wellbeing of self and others, the resident's wandering behavior was likely to affect the privacy of others, and the resident was recently admitted and not accepting of the situation. A Risk for Elopement Assessment, dated 3/17/26, indicated Resident C was at risk for elopement due to having verbally expressed a desire to go home.Resident C's physician orders included, but were not limited to, check placement and functioning of Wandergaurd every shift (started 8/18/25).Resident C's care plan included but was not limited to resident is at risk for elopement related to her Alzheimer's disease, dementia and aimless wandering. A Wanderguard has been placed to resident's ankle (initiated 8/25/25). Resident C's nurse's progress notes included, but were not limited to:On 8/20/25 at 9:46 A.M., Resident's Wanderguard was in place on the right ankle. Resident wanders looking for room at times. On 4/11/26 at 2:33 P.M., Activity Assistant 4 stated that Resident C had been outside on the porch and that Activity Assistant 4 assisted another resident into the facility. When she returned outside, Resident C was no longer on the porch. Staff searched in and around the facility before realizing the resident could not be located. 911 was called at approximately 2:41 P.M. to notify (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	them of a resident elopement from the facility. On 4/11/26 at 2:47 P.M., Resident C was brought back to the facility by a community bystander that happened to drive by the resident. She thought it was odd that the resident had such warm clothes on to be outside and appeared to be lost. The resident asked to be brought home when offered by the community member. No visible injuries noted. On 4/11/26 at 3:39 P.M., at 2:33 P.M., the facility phone rang and Activity Assistant 4 asked the nurse if Resident C had come inside. Resident C was outside with Activity Assistant 4 when the activity assistant came inside for about five minutes and left the residents on the porch alone, when she returned to the porch, Resident C was no longer there.During an interview on 4/15/26 at 11:45 A.M., RN 7 indicated Resident C did wander in the facility and would go to the exit doors and push buttons on the keypad but would not be able to get out due to the doors being locked. Resident C was easily redirected when near an exit. During an interview on 4/15/26 at 12:50 P.M., Activities Assistant 4 indicated being aware of Resident C's diagnosis of dementia but was not aware of Resident C's risk for elopement. During an interview on 4/15/26 at 1:27 P.M., Activities Assistant 6 indicated being aware of the resident's dementia diagnoses, but was not aware, prior to Resident C's elopement on 4/11/26, that she was an elopement risk. During a review of the facility's investigation of the elopement incident on 4/15/26 at 12:00 P.M., a written statement by Activities Assistant 4, dated 4/11/26, included that Activities Assistant 4 acknowledged that the residents with a dementia diagnosis should not be left unattended outside. On 4/15/26 at 12:00 P.M., the Facility Administrator supplied a facility policy titled, Wandering and Elopements, dated 2026. The policy included, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety . The Immediate Jeopardy that began on 4/11/26 was removed on 4/16/26, when the facility completed audits for residents at risk for elopement, educated staff on the elopement policy, and implemented policy changes on outdoor activities but the noncompliance remained at the lower scope and severity, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This citation relates to Intake 2981023.410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)