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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Retirement Community	720 E Dustman Rd Bluffton, IN 46714

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44036 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). 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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	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)