

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2024
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NAME OF PROVIDER OR SUPPLIER  AVALON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 6021 S ARLINGTON AVENUE INDIANAPOLIS, IN 46237
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R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00443559.</p> <p>Complaint IN00443559 - State deficiencies related to the allegations are cited at R0052.</p> <p>Survey date: September 24, 2024</p> <p>Facility number: 015486</p> <p>Residential Census: 51</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed September 27, 2024.</p>	R 0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Submission of this plan of correction shall serve as credible evidence of substantial compliance with the alleged deficiency. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
R 0052  Bldg. 00	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense</p> <p>Based on observation, interview, and record review, the facility failed to protect the residents right to be free from neglect for 3 of 3 residents reviewed for elopement. Cognitively impaired residents who resided on the secured memory care unit exited into an unsecured courtyard without staff supervision. (Resident B, Resident C, Resident D)</p> <p>Finding includes:</p> <p>During an interview on 9/24/24 at 9:39 a.m., CNA 1 indicated Resident B, Resident C, and Resident D walked out of the facility through the memory care exit door to the front patio.</p> <p>On 9/24/24 at 9:52 a.m., observed the memory care</p>	R 0052	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The three noted residents received monitoring every 15 minutes until doors were serviced on 09/19/2024 by Broad Ripple Lock. All staff in-serviced on preventing elopements.</p> <p><b>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</b></p>	10/11/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jerrilynn Morehous	Executive Director	10/11/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>exit door that led to the front patio. A large, locked glass exit door led to the front memory care patio. The patio was located at the front of the facility and was approximately 15 feet wide by 15 feet long and was open to the parking lot. The main road was approximately 100 yards from the patio.</p> <p>During an interview on 9/24/24 at 10:18 a.m., the Director of Nursing (DON) indicated, on 9/8/24 at approximately 6:00 p.m., Resident B pushed on the front memory care exit door to the patio for 15 seconds and walked outside to the front patio without staff supervision. The DON indicated a second event of unsafe wandering occurred, on 9/11/24 at approximately 10:30 a.m., when Resident B pushed on the front exit door of the MCU (Memory Care Unit), the door opened, and Resident B exited the secured unit to the front patio without staff supervision. The DON indicated another cognitively impaired resident who resided on the MCU (Resident C) exited the secured unit at the same time. The DON indicated a third event of unsafe wandering occurred, on 9/18/24 at approximately 9:30 p.m., when Resident D pushed on the front door of the MCU and exited the unit without staff supervision.</p> <p>1. The clinical record for Resident B was reviewed on 9/24/24 at 11:06 a.m. The diagnoses included, but were not limited to, dementia and congestive heart failure.</p> <p>An initial evaluation, dated 9/7/24, indicated Resident B was not capable of making any independent choices, was oriented to person but seldom to place or time. Resident B required close supervision in a secured location to prevent unsafe wandering.</p> <p>A progress note, dated 9/8/24 at 6:18 p.m.,</p>		<p><b>taken?</b></p> <p>All residents in memory care were assessed for exit seeking and potential for elopement by 10/11/2024.</p> <p><b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b></p> <p>Doors in memory care inspected and updated as needed by Broad Ripple Lock on 9/19/2024. Service plans were updated based on assessments for exit seeking and potential for elopement. Policy reviewed and revised on 9/25/2024. All staff in-serviced on elopement and resident rights.</p> <p><b>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?</b></p> <p>Director of Maintenance or designee will audit doors in memory care for proper function and egress. Audits will occur once weekly for one month then monthly for two months. Monitoring will be ongoing through 12/31/2024.</p> <p><b>By what date will the systemic changes be completed?</b></p> <p>10/11/2024</p>	

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	<p>indicated staff notified writer that the front memory care exit door alarmed and Resident B was found standing unattended with his walker outside on the patio before the sidewalk. Resident B stated he was going home.</p> <p>A progress note, dated 9/11/24 at 10:21 a.m., indicated the nurse noted the west end exit door on the MCU was alarming. Resident B walked around the patio and past the window. Resident B was redirected back into building without issue.</p> <p>2. The clinical record for Resident C was reviewed on 9/24/24 at 10:53 a.m. The diagnoses included, but were not limited to, dementia and sleep apnea.</p> <p>A Change of Condition Evaluation, dated 8/16/24, indicated Resident C was not capable of making any independent choices, was oriented to person but seldom to place or time, and had little short-term memory recall. Resident C exhibited purposeful exit seeking behaviors, frequently searched for home, grasped at doorknobs and handles without purpose, and followed visitors closely.</p> <p>A progress note, dated 9/11/24 at 10:13 a.m., indicated the nurse noted the alarm was activated at the MCU front patio exit door. Resident B was outside on the patio and Resident C walked back inside the facility from the patio.</p> <p>3. The clinical record for Resident D was reviewed on 9/24/24 at 10:33 a.m. The diagnoses included, but were not limited to, dementia and hypertension.</p> <p>An Initial Evaluation, dated 7/22/24, indicated Resident D was incapable of participating in decision making process, Resident D was oriented</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2024

FORM APPROVED

OMB NO. 0938-039

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	<p>to person but rarely oriented to place or time, and Resident D required close supervision in a secured location to prevent unsafe wandering.</p> <p>A progress note, dated 9/18/24 at 2:17 p.m., indicated Resident D was walking up the hall pulling a laundry basket full of her clothes. Resident D insisted she was going to walk home.</p> <p>The progress notes lacked sufficient information to determine the details of the actual elopement, on 9/18/24 at approximately 9:30 p.m., from the secured MCU.</p> <p>During an interview on 9/24/24 at 11:30 a.m., the Administrator indicated the facility policy was to prevent elopements.</p> <p>On 9/24/24 at 1:00 p.m., the facility was unable to provide a policy regarding elopements.</p> <p>This citation relates to Complaint IN00443559.</p>			