

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/22/2024
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NAME OF PROVIDER OR SUPPLIER  HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 2494 N LEBANON ST LEBANON, IN 46052
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Nursing Home Complaints IN00439970, IN00439455, IN00440142, IN00439961, IN00438556, and IN00438514. This visit included a the Investigation of Residential Complaints IN00439970 and IN00439455.</p> <p>Complaint IN00439970 - Federal deficiencies related to the allegation(s) are cited at F0609 and F0610.</p> <p>Complaint IN00439455 - Federal deficiencies related to the allegation(s) are cited at F0609 and F0610.</p> <p>Complaint IN00440142 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00439961 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00438556 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00438514 - No deficiencies related to teh allegations are cited.</p> <p>Survey dates: August 21 and 22, 2024</p> <p>Facility number: 002703 Provider number: 155680 AIM number: 200309250</p> <p>Census Bed Type: SNF/NF: 42 SNF: 7 Total: 49</p> <p>Census Payor Type: Medicare: 4 Medicaid: 32 Other: 13</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amisha Shah	Executive Director	09/16/2024

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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F 0609 SS=D Bldg. 00	<p>Total: 49</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 3, 2024.</p> <p>483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations</p> <p>Based on observation, interview, and record review, the facility failed to ensure an elopement of a resident was reported to the Indiana Department of Health for 1 of 2 residents reviewed for elopement (Resident B).</p> <p>Finding includes:</p> <p>During an observation on 08/20/24 at 8:58 a.m., Resident B was in her room dressed, clean and dry and wearing a wander guard bracelet on her wrist. She was alert, able to sit up on the side of the bed without assistance and very friendly. She currently resided in the Legacy Memory Care Unit of the Assisted Living Facility. Her wheel chair was noted to be parked in close proximity to her bed and within reach.</p> <p>During an interview on 08/21/24 at 10:29 a.m., the Corporate Support Nurse indicated on 07/18/24, Resident B exited the campus out the 300 hall door. The alarm did sound and a family member observed the resident exit and reported it to staff immediately. The staff responded. The resident used the side walk to the Health Care Center parking lot and crossed the street. She was observed by the home owner, across the street, who was out in the yard. Responding staff did get to the resident. It took about three (3) minutes.</p>	F 0609	<p>1) Immediate actions taken for those residents identified:</p> <p>Resident B was affected. Education completed with staff regarding reporting guidelines/ reporting incidents/ completing investigations to ensure Resident Safety.</p> <p>2) How the facility identified other residents:</p> <p>All residents have the potential to be affected. All residents were assessed for elopement risk and plan of care was updated accordingly.</p> <p>3) Measures put into place/ System changes:</p> <p>As a measure of ongoing compliance, the ED or designee will complete an audit to ensure any elopement incident is investigated and reported to IDOH in a timely manner.</p> <p>4) How the corrective actions will</p>	09/15/2024

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	<p>The resident had been last observed by a nurse at 8:22 p.m. The nurse then had to go print reports, due to the internet outage. The responding staff returned Resident B to the facility at 8:33 p.m. Staff did all the right things (followed the elopement policy) and it was documented on paper (due to the system being down). It was not reported to the state because the Corporate Support Nurse had not been made aware of the incident. The Director of Nursing, at the time told the CNAs to falsify documentation. The Executive Director told the CNAs to report the facts. It was reported to the Executive Director. Attempts to contact the Director of Nursing were made, but she would not respond and she did not return to the facility. The incident was treated like it happened 08/20/24 and the report to the state was currently in process.</p> <p>During an observation on 8/21/22 at 10:33 a.m., the road next to the facility was noted to allow two way traffic and had a speed limit of 30 miles per hour. The road ran east to west. The house was noted to be directly across the street from the Health Care parking lot and entrance. There was little traffic at that time of the day. There was no answer at the house. A second attempt to speak with the occupant of the house was made at 12:45 p.m. There was no answer.</p> <p>During an interview on 8/21/24 at 12:47 p.m., CNA 1 indicated last month (July 2024) the computer system was out. Staff was getting residents ready for bed. He was in the 100 hall and the CNA 2 went to get supplies. A family member stopped CNA 2 to inform her an alarm was sounding in the 300 Hall and a resident left and had not come back. CNA 1 and CNA 2 did a head count and searched the rooms in the 300 Hall. CNA 1 was unable to identify how long it took to check the</p>		<p>be monitored:</p> <p>The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.</p>	

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	rooms and do the head count. Both CNAs then went outside via the emergency door of the 300 unit, where the alarm was sounding. The went to the parking lot in the back of the facility and observed the resident across the street. The neighbor, across the street, was under his car. The CNAs returned the resident, the resident seemed "o.k." They entered the facility using the main door to the Assisted Living and took the resident to the nurse. CNA 2 did place calls to the Executive Director, while they were with the resident, across the street. She tried to contact all of management. The Executive Director did finally answer. The Executive Director was made aware of the incident while they were across the street with the resident. The Director of Nursing, at that time, was in the Assisted Living facility. They took the resident to the nurse and went back to patient care. While they were assisting residents the former Director of Nursing came to the room they were working in and told both CNAs they needed to write a statement. While they were still providing care, in the room, he indicated the former Director of Nursing told them to write a statement to indicate the resident did not make it across the street and she was in full sight the whole time. He refused to write a statement and indicated it was not true and the Director of Nursing was informed that would be falsification. The former Director of Nursing left. She returned about five (5) minutes later and informed CNA 1 she had spoke with the Executive Director and the Executive Director said to write the statement, give the facts, so the incident could be reported. He did not write the statement. The next day the Executive Director asked him to write the statement. She pulled him into an empty room on the 300 unit and asked him what was wrong. He was frustrated and felt both the Executive Director and former Director of Nursing wanted him to			

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	<p>falsify a statement. The Executive Director indicated the Director of Nursing was leaving anyway; he still refused to write a statement.</p> <p>During an interview on 8/21/24 at 2:15 p.m., CNA 2 indicated CNA 1 and her were working on the floor, she had finished her work on her hall and CNA 1 asked her to get supplies. On her way back, a family member stopped her and said an alarm was going off. She asked if the family member had seen a lady in a wheelchair and the family member responded yes. She went to CNA 2 and informed him. Both CNAs went to the 300 Hall and searched the rooms, Resident B was not found. They both walked out of the building and observed Resident B across the street. The neighbor was under his car working. CNA 2 indicated she apologized, and the neighbor responded it was o.k. She then made calls to the Director of Nursing, Executive Director, and the MDS Coordinator. None of them answered. She kept calling the Executive Director and she finally answered. CNA 2 indicated the Executive Director was informed of the incident while both CNAs were in the neighbor's driveway. CNA 2 indicated the Executive Director kept saying, "so she [Resident B] was inside the whole time." CNA 2 indicated she responded, "no that is not what happened". The Director of Nursing was in the facility on the Assisted Living side. The Executive Director informed CNA 2 that she would call the Director of Nursing and inform her. A little later the Director of Nursing came and told both CNA 1 and CNA 2 not to include, in their statements, that the resident was across the street. CNA 2 asked the Director of Nursing if she wanted them to lie and per the CNA, the Director of Nursing responded it was not lying it was emphasizing. CNA 2 did not write any statements.</p>			

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	<p>During the interview CNA 2 shared her phone record. It was noted calls were placed on 07/18/24 to the Executive Director twice with a history of 2 seconds as well as the other management staff, also 2 seconds. On July 18, 2024 at 8:32 p.m., the third call to the Executive Director had a duration of one (1) minute.</p> <p>During an interview on 08/21/24 at 3:49 p.m. the Executive Director indicated she was notified that Resident B had eloped off campus, the same day it happened. She was told the resident was within the line of sight. She realizes now it should have been reported and it will not happen again. At the time the facility records system was off-line due to outages that affected the country. There was a lot happening. She did get the call and it was quick. She did not get a lot of details. After the incident occurred, she did ask for witness statements and was told they (the CNAs) would type them up. They did not type up statements. She indicated she did try to contact the Director of Nursing and was not able to contact her. She never questioned if the incident needed to be reported to the state agency.</p> <p>During a telephone interview on 08/21/24 at 4:00 p.m., the former Director of Nursing indicated on that evening (July 18, 2024) she was on her way to the facility to print paperwork due to the system was down. She did not have password access to the area of the system, but she was going to try to print the information. While on her way to the facility she received a call from the Executive Director and was informed of the incident and told to assess Resident B.</p> <p>The record for Resident B was reviewed on 08/21/24 at 9:54 a.m. Diagnoses included, but were not limited to unspecified dementia,</p>				

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	<p>unspecified fracture of the lower end of the right femur (upper leg) and chronic diastolic heart failure.</p> <p>The resident admitted to the Health Care Center on 06/01/24 and was transferred to the locked memory care unit on the assisted living on 07/23/24.</p> <p>The resident had a Brief Interview for Mental Status (BIMS) assessment score of 5 indicating the resident had severe cognitive impairment dated 06/27/24.</p> <p>The progress notes indicated Resident B had exited the building using an emergency exit on 07/07/24 but she had not got off of the facility property. Staff responded promptly and returned the resident to the facility. The resident was placed in the memory care activity program and engaged in activity. She was noted, on 07/09/24, to self propel herself in her wheel chair and wander into other residents' rooms. On 07/15/24 Resident B was self propelling her wheel chair and asking which exit would get her to the "...front of the nursing building..." On 07/16/24 a note indicated Resident B had attempted to exit the doors at the end of the hall twice. The alarms sounded and staff returned the resident to the common area. She was then taken to the Legacy Memory Care Unit, a locked unit, for the remainder of the day.</p> <p>A nursing note, dated 07/18/24 at 11:45 p.m. indicated the resident was in bed, she had no exit seeking behavior on the shift. The resident was on safety checks. She had no complaints of pain and staff would continue to monitor. The signature of the writer was not legible.</p>			

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	<p>An Interdisciplinary Team note, dated 07/19/24 at 9:30 a.m., indicated the resident had exited the campus on 07/18/24 by way of the 300 Hall emergency exit and was brought back inside by staff at 8:33 p.m. The resident was assessed and denied any pain, She was put on 1 on 1 observation until she was calm. It was noted the wander guard was in place. The resident indicated she was checking the cats. She was found to be dressed appropriately in jeans, sweater, socks and shoes. She was not found to have any psychosocial distress. She was unable to recall the events.</p> <p>A document titled "INDIANA STATE DEPARTMENT OF HEALTH SURVEY REPORT SYSTEM" was received from the Corporate Support Nurse on 08/21/24 at 2:43 p.m. The report was filed to the Indiana State Department of Health on 08/21/24 (33 days after the incident). The incident was dated 07/18/24 and the description indicated, "...8/21/24 Resident exited the campus and went across the street safely to visit with neighbor ...."</p> <p>A facility policy related to reporting incidents to the Indiana Department of Health was requested of the Corporate Support Nurse. A policy titled, "External Reporting", last reviewed on 12/31/23 and received from the Corporate Support Nurse on 08/21/24 at 2:43 p.m., did not cover reporting incidents to Indiana Department of Health. At the time the policy was provided the Corporate Support Nurse indicated the facility followed the state regulations and the incident should have been reported to the state.</p> <p>A facility document titled, "CHECKLIST FOR POST ELOPEMENT," dated 08/20/24, and received from the CSN on 08/21/24 at 2:43 p.m., indicated</p>			

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F 0610 SS=D Bldg. 00	<p>"...ED/DHS...assist with investigation/audits...ED/DHS or designee to start investigation: get statements from employees nursing and non-nursing...Have DVP and Clinical Support review and approve reportable paperwork before sending to agencies (State Department of Health, Ombudsman, Adult Protective Services, and or local law enforcement as indicated...Complete five day final and have DVP and Clinical Support review and approve prior to sending to agencies...."</p> <p>This citation relates to Complaints IN00439455 and IN00439970.</p> <p>3.1-28(c)</p> <p>483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation</p> <p>Based on observation, interview, and record review, the facility failed to timely investigate an elopement when the incident occurred for 1 of 1 resident, reviewed for eloping from the facility (Resident B).</p> <p>Finding includes:</p> <p>During an interview on 08/21/24 at 10:29 a.m., the Corporate Support Nurse indicated on 07/18/24, Resident B exited the campus out the 300 hall door. The alarm did sound and a family member observed the resident exit and reported it to staff immediately. The staff responded. The resident used the side walk to the Health Care Center parking lot and crossed the street. She was observed by the home owner, across the street, who was out in the yard. Responding staff did get to the resident. It took about three (3) minutes. The resident had been last observed by a nurse at</p>	F 0610	<p>1) Immediate actions taken for those residents identified: Resident B was affected. Education completed with staff regarding reporting guidelines/ reporting incidents/ completing investigations to ensure Resident Safety.</p> <p>2) How the facility identified other residents:  All residents have the potential to be affected.</p> <p>3) Measures put into place/ System changes:  As a measure of ongoing compliance, the ED or designee</p>	09/15/2024

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	<p>8:22 p.m. The nurse then had to go print reports, due to the internet outage. The responding staff returned Resident B to the facility at 8:33 p.m. Staff did all the right things (followed the elopement policy) and it was documented on paper (due to the system being down). It was not reported to the state because the Corporate Support Nurse had not been made aware of the incident. The Director of Nursing, at the time) told the CNAs to falsify documentation. The Executive Director told the CNAs to report the facts. It was reported to the Executive Director. Attempts to contact the Director of Nursing were made, but she would not respond and she did not return to the facility. The incident was treated like it happened yesterday (08/20/24) and the report to the state was currently in process.</p> <p>During an observation on 8/21/22 at 10:33 a.m., the road was noted to allow two way traffic and had a speed limit of 30 miles per hour. The road runs east to west. The house was noted to be directly across the street from the Health Care parking lot and entrance. There was little traffic at that time of the day. There was no answer at the house. A second attempt to speak with the occupant of the house was made at 12:45 p.m. There was no answer.</p> <p>A facility document titled, "Trilogy Health Services, LLC Statement of Witness Form," dated 08/20/24. and received from the Corporate Support Nurse on 08/21/24 at 2:43 p.m., indicated, on 07/18/24 the charting system went down and staff were unable to access the electronic medical record system. The writer went to the Assisted Living and attempted to get the offline Medication and Treatment Records for the residents. She returned to the hall at 8:33 p.m. At that time the CNAs were bringing Resident B down the</p>		<p>will complete an audit to ensure any elopement incident is investigated and reported to IDOH in a timely manner.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met.</p>	

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	<p>hallway. The CNAs stated the resident had exited the facility from the 300 Unit door and had been found outside. The writer took the resident to her room and assessed her. No injuries were noted and the resident's wander guard was in place. The resident was then placed on monitoring. The Executive Director(ED), Director of Nursing (DHS), and Nurse Practitioner (NP) were notified. The last time the resident was observed by the writer was shortly prior to her going to the Assisted Living side of the facility at 8:20 p.m. The resident was up and in her wheel chair at the time. The document was dated 08/20/24 and signed by RN 3.</p> <p>A facility document titled, "Trilogy Health Services, LLC Statement of Witness Form," dated 08/20/24 and received from the Corporate Support Nurse on 08/21/24 at 2:43 p.m., indicated, on 07/18/24 the writer was assisting CNA 1 with a resident. She went to get resident care items and was informed by a family member an alarm was sounding on the 300 Hall. The writer asked the family member if a resident had exited the door and returned. The family member informed her a resident went out but she did not see the resident return. CNA 1 was informed of the incident and both staff members checked the residents. They found that Resident B was not in the campus. She then went outside and upon exiting the Health Center door she observed Resident B across the street with the neighbor. The resident was returned to the facility and RN 3 assessed her. The ED and DHS were made aware. The document was dated 08/20/24 and signed by CNA 2.</p> <p>A facility document titled, "Trilogy Health Services, LLC Statement of Witness Form," dated 08/20/24, and received from the Corporate Support Nurse on 08/21/24 at 2:43 p.m., indicated, on</p>			

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	<p>07/18/24, the writer was working on his hall, putting residents to bed. CNA 2 was assisting. CNA 2 went to get supplies that were needed and when she returned she informed him an alarm was sounding and they needed to do a head check (check all residents). They realized Resident B was not in the campus and CNA 2 went outside and found the resident across the street at the neighbors house. They returned the resident back to the facility and RN 3 was notified. The ED and DHS were also notified. The document was dated 08/20/24 and signed by CNA 1.</p> <p>A facility document titled, "Trilogy Health Services, LLC Statement of Witness Form," dated 08/20/24, and received from the Corporate Support Nurse on 08/21/24 at 2:43 p.m., indicated the writer was not made aware Resident B had exited the campus and was "...without remaining in the line of sight....". A staff member did "...reach out...." to her but no details were provided with the exception that the incident had been reported to the DHS. She requested the staff members write out a statement and submit it to the DHS, but they refused to write the witness statements at that time. The document referenced the incident date as 07/18/24, was dated 08/20/24 and signed by the ED.</p> <p>A facility document titled, "Trilogy Health Services, LLC Statement of Witness Form," dated 08/20/24, and received from the Corporate Support Nurse on 08/21/24 at 2:43 p.m., indicated the DHS notified the writer a resident had exited the facility but was "...within sight....". She reviewed the Interdisciplinary Team note the next day and "...no concerns were noted....". The document referenced the incident date as 07/18/24, was dated 08/20/24 and signed by the ED.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/22/2024
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NAME OF PROVIDER OR SUPPLIER  HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 2494 N LEBANON ST LEBANON, IN 46052
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R 0000  Bldg. 00	<p>A facility document titled, "Trilogy Health Services, LLC Statement of Witness Form," dated 08/20/24, and received from the Corporate Support Nurse on 08/21/24 at 2:43 p.m., indicated the neighbor, living directly across from the Health Care entrance (located on West 250 N.) stated at approximately 8:25 p.m. (07/18/24) he noted the resident "...tooling around on sidewalk of Homewood building and in parking lot...." The resident crossed the street and was friendly and began a conversation with him. Someone from the facility then came approximately two (2) minutes later and took the resident back to the facility. The document had no signature of the neighbor and was dated 08/20/24.</p> <p>A facility docent titled, "CHECKLIST FOR POST ELOPEMENT," dated 08/20/24, and received from the CSN on 08/21/24 at 2:43 p.m., indicated "...ED/DHS...assist with investigation/audits...ED/DHS or designee to start investigation: get statements from employees nursing and non-nursing...Have DVP and Clinical Support review and approve reportable paperwork before sending to agencies (State Department of Health, Ombudsman, Adult Protective Services, and or local law enforcement as indicated...Complete five day final and have DVP and Clinical Support review and approve prior to sending to agencies...."</p> <p>This citation relates to Complaints IN00439455 and IN00439970.</p> <p>3.1-28(e)</p> <p>This visit was for the Investigation of Complaint</p>	R 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155680	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2024
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NAME OF PROVIDER OR SUPPLIER  HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052
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	<p>IN00439455 and Complaint IN00439970. This visit included the investigation of Nursing Home Complaints IN00439970, IN00439455, IN00440142, IN00439961, IN00438556, and IN00438514.</p> <p>Complaint IN00439970 - Federal deficiencies related to the allegation(s) are cited at F0609 and F0610.</p> <p>Complaint IN00439455 - Federal deficiencies related to the allegation(s) are cited at F0609 and F0610.</p> <p>Complaint IN00440142 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00439961 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00438556 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00438514 - No deficiencies related to the allegations are cited.</p> <p>Survey date: August 21 and 22, 2024.</p> <p>Facility number: 002703</p> <p>Residential Census: 31</p> <p>Homewood Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00439455 and Complaint IN00439970.</p> <p>Quality review completed on September 3, 2024.</p>			