STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS OF COLUMBUS	4300 WEST GOELLER BLVD COLUMBUS, IN 47201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00397222 and IN00391651. Complaint IN00397222 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00391651 - Substantiated. State deficiency related to the allegation is cited at R0052. Survey dates: December 20 and 21, 2022 Facility number: 015179 Residential Census: 81 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on December 30, 2022.	R 0000	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 any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **In response to R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights** **Deficiency:** **(V) Residents have the right to be free from:** **(1) Sexual Abuse;** **(2) Physical Abuse;** **(3) Mental Abuse;** **(4) Corporal Punishment;** **(5) Neglect; and** **(6) Involuntary Seclusion.** **What corrective actions will be accomplished for those residents found to have been affected by the finding:** The resident was placed on a 1:1 supervision until exhibiting no signs of exit seeking during incident. Resident identified as "high risk" for elopement and Care Plan was updated to identify this	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacey Gallardo	Executive Director	01/12/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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			risk. -Completed 12/30/22 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place: No resident was adversely affected though the potential for adverse outcome did exist. The memory care director will continue to identify residents 'at risk' for elopement upon admission and with each care plan/ assessment thereafter. The documentation of screening will be kept in the resident's medical chart. Residents that are identified as high risk will have such findings on their face sheet of care plan as well as name will be added to the elopement list at our nursing care base. -Completed 12/30/22 and ongoing **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** The Director of Wellness along with the Memory Care Director will screen all new admission for	

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			elopement risk. The documentation of screening will be kept in the resident's medical chart. -Completed 12/30/22 and ongoing monthly The Executive Director conducted an Inservice for employees to review elopement policy and procedures. The Executive Director will retain documentation of the Inservice. -Completed 12/28/22 An elopement drill will happen every month to train staff on elopement response. Documentation of drills will be obtained by Executive Director. Completed 12/28/22 and ongoing monthly Elopement Policy and Procedures will be reviewed during general orientation for each new employee. Documentation of this will be kept in each employee file. -Completed 12/30/22 and ongoing **What date the systemic changes will be completed:** 12/30/22 and ongoing	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse;			

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	(4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to provide a safe environment and prevent an elopement for 1 of 3 residents reviewed for neglect. (Resident B) Findings include: The Clinical Record for Resident B was reviewed on 12/20/22 at 4:21 p.m. The diagnoses include but were not limited to, Alzheimer's Disease, obstructive sleep apnea, and Type 2 Diabetes Mellitus. An Admission Evaluation, dated 8/30/22, indicated the resident had wandered intrusively, but was easily redirected or wandered in public, but was not intrusive. Minimal interventions were needed one to two times monthly to manage episodes of agitation, anxiousness, or repetitive behaviors. During an interview on 12/20/22 at 3:31 p.m., the Administrator indicated Resident B was found off the unit. He had exited the Memory Care Unit using the "green door" and was in the back of the building. A staff member had stuck her head out of the alarming door, did not see a resident and closed the door. She then did a head count and found to be one resident short. She returned to the door and the resident was in the alley behind the building. Facing the back of the building. During an interview on 12/20/22 at 3:59 p.m., CNA (Certified Nurse's Aide) 3 indicated an Activity Aide heard the exit door alarm going off, looked out the door, did not see a resident and closed the door. Staff did a head count, realized Resident B	R 0052	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 any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. **In response to R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights** **Deficiency:** **(V) Residents have the right to be free from:** **(1) Sexual Abuse;** **(2) Physical Abuse;** **(3) Mental Abuse;** **(4) Corporal Punishment;** **(5) Neglect; and** **(6) Involuntary Seclusion.** **What corrective actions will be accomplished for those residents found to have been affected by the finding:** The resident was placed on a 1:1 supervision until exhibiting no signs of exit seeking during incident. Resident identified as "high risk" for elopement and Care Plan was updated to identify this	12/30/2022

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	was missing, They paged a Silver Alert (missing resident) overhead. The staff found the resident outside, at the back of the building, in the paved alley, eating a cookie. During an interview on 12/20/22 at 4:02 p.m., LPN (Licensed Practical Nurse) 2 indicated there had been a telephone call from the house behind the facility. The caller indicated an elderly gentleman was in the parking lot. Another staff member took the call, notified her and then they had done a head count to determine who was missing, The staff were in a panic. She heard beeping but did not know what it was. Someone reset the door because they did not think anyone was outside. The door Resident B exited went into a hallway where there were two doors, one to the kitchen and one to the outside of the building. The kitchen staff used that door to deliver meals. Even when staff put in the code, the door beeped and let you know the door was being opened. She just thought it was the kitchen or the front entry door sounding and did not realize it was the fire exit door. The resident must have pushed on the bar, the alarm started beeping, and then he was able to open it and exit the unit. During an interview on 12/21/22 at 9:37 a.m., LPN 2 indicated on 10/1/22 Resident B was observed in the grass between the utility pole and third tree next to the street. The resident was approximately 500 feet down the street from the facility. He was wearing a shirt, long pants, and shoes. They figured the resident was out of the facility for about 5 minutes. During an interview on 12/21/22 at 1:49 p.m., CNA 7 indicated when she last saw Resident B, he was up in the front, near the TV room. She never heard the alarm going off. There was an Activity Aide in		risk. -Completed 12/30/22 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place: No resident was adversely affected though the potential for adverse outcome did exist. The memory care director will continue to identify residents 'at risk' for elopement upon admission and with each care plan/ assessment thereafter. The documentation of screening will be kept in the resident's medical chart. Residents that are identified as high risk will have such findings on their face sheet of care plan as well as name will be added to the elopement list at our nursing care base. -Completed 12/30/22 and ongoing **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** The Director of Wellness along with the Memory Care Director will screen all new admission for	

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	the kitchen area and there were other CNAs in a resident's room. The Activity Aide told her Resident B was gone, so she went to the hall where he was last seen. She had a walkie talkie but no pager. She called a Silver Alert over the walkie talkie. She exited the building and a guy from the house at the right of the facility waved at her, he said the resident was in his yard. She found Resident B sitting on the ground in his yard. The resident appeared to be "worn out," hot and sweaty. He was wearing jeans, a blue sweater, and white tennis shoes. Upon return to the building staff did a head count. A nurse's note, dated 10/1/22 at 4:00 p.m., indicated the alarm on the back door of the memory care unit was going off. An activities staff member went to the door and saw it was open. The staff member looked out of the door; then reported that Resident B was last seen near the end of that hallway and was no longer there. The staff started to search rooms immediately. Resident B was not located inside of the facility. The staff member went outside to start searching for the resident. The staff member alerted LPN 2 on the AL (Assisted Living) there was a resident missing. The resident was found outside of the facility in the alley behind the facility. A head count was conducted once the resident was brought back into the facility. A nurse's note, dated 9/23/22 at 5:50 p.m., indicated the resident was ambulating in the hallways most of the day, he repeatedly wandered into other residents' apartments, which was making them very upset or scared. The DOW (Director of Wellness) was made aware of the current situation. A nurse's note, dated 9/20/22 at 11:52 a.m.,		elopement risk. The documentation of screening will be kept in the resident's medical chart. -Completed 12/30/22 and ongoing monthly The Executive Director conducted an Inservice for employees to review elopement policy and procedures. The Executive Director will retain documentation of the Inservice. -Completed 12/28/22 An elopement drill will happen every month to train staff on elopement response. Documentation of drills will be obtained by Executive Director. Completed 12/28/22 and ongoing monthly Elopement Policy and Procedures will be reviewed during general orientation for each new employee. Documentation of this will be kept in each employee file. -Completed 12/30/22 and ongoing **What date the systemic changes will be completed:** 12/30/22 and ongoing	

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	indicated there was an incident were a resident said a man was in her bathroom on the floor, and needed help. Staff went to the room and found Resident B bent down on one knee, picking paper up off the floor. He had no injuries and was able to get up with staff assistance. A nurse's note, dated 8/31/22 at 5:38 a.m., indicated Resident B had some exit seeking behaviors. A nurse's note, dated 8/30/22 at 5:00 p.m., indicated Resident B was exit seeking that morning. A nurse's note, dated 8/30/22 at 5:56 a.m., indicated Resident B had some exit seeking behaviors earlier in the night. A nurse's note, dated 8/29/22 at 6:10 p.m., indicated Resident B arrived at facility via family's personal vehicle. He was oriented to self only and ambulated without assistive devices. He refused to eat because he said he was going home. He had carried his belongings in a laundry basket, thinking he was leaving. The resident had been going to the doors and setting off the alarms. The current facility policy, "Residency Agreement," and not dated, was provided by the Administrator on 12/20/22 at 3:11 p.m. The Policy indicated, " ...P. Residents' Rights ...(v) Residents have the right to be free from ...(5) neglect..." The current facility policy, "Elopement/Missing Resident," and dated 6/14, was provided by the LPN on 12/21/22 at 10:14 a.m. The Policy indicated, " ...personnel who have residents under their care are responsible for knowing the location of those residents ...Procedure: Missing Resident			

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	Procedure ... 4. Record all pertinent information in resident's medical record. Fully describe the sequence of events ..." The current facility policy, "Resident Evaluation," and dated 6/14, was provided by the Administrator on 12/21/22 at 2:00 p.m. The Policy indicated, " ...This community shall complete an evaluation of the individual needs of each resident ...to determine if the residents' health care needs can be adequately met by the facility ...5. Once the evaluation is completed the Wellness Director will determine if the resident is appropriate for living at the community..." This Residential tag relates to Complaint IN00391651.			