

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 03/19/2024
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NAME OF PROVIDER OR SUPPLIER MORNING POINTE OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP COD 75 S MILFORD DR FRANKLIN, IN 46131
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(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	<p>This visit was for the Investigation of Complaint IN00430745.</p> <p>Complaint IN00430745 - State deficiencies related to the allegations are cited at R0052.</p> <p>Survey date: March 19, 2024</p> <p>Facility number: 002858</p> <p>Residential Census: 43</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed March 20, 2024.</p>	R 0000		
R 0052 Bldg. 00	<p>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; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 3 residents reviewed. A staff member left a secured memory care side door unalarmed and unsupervised for 4 hours. This deficient practice resulted in a cognitively impaired resident exiting the facility through the unalarmed door without staff knowledge. (Resident B)</p> <p>Finding included:</p>	R 0052	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; POA, ED, PCP, and Regional directors were all immediately notified. Resident was sent to the E.R. for further evaluation. Doors were assessed and secured by maintenance director. All on site team members were educated	03/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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>During an interview on 3/19/24 at 8:29 a.m., the Administrator indicated on 3/17/24 at approximately 2:25 p.m., Resident B walked out the north emergency exit door of the secure memory care unit. QMA 1 had used a key to turn the alarm off to the north emergency exit door because there was a family member moving furniture off the unit. At approximately 2:38 p.m., Resident B was brought back to the facility by a neighbor that lived 3 houses down. The neighbor found Resident B sitting quietly on her front porch.</p> <p>During an interview on 3/19/24 at 8:53 a.m., QMA 1 indicated a family member was at the facility on 3/17/24, moving furniture out of the facility. QMA 1 used a key to turn off the alarm to the north emergency exit door on the memory care unit. The family member was supposed to tell QMA 1 when he was finished moving furniture, but QMA 1 was never notified and forgot the alarm was turned off. QMA 1 finished her shift and left the facility on 3/17/24 at approximately 2:07 p.m. QMA 1 received a phone call from the facility and asked if QMA 1 had unlocked the north emergency door. That was when QMA 1 realized the door alarm had been turned off for approximately 4 hours.</p> <p>On 3/19/24 at 9:18 a.m., the Administrator provided a list resident at the facility. A review of the list, indicated 12 residents resided on the secured memory care unit.</p> <p>The clinical record for Resident B was reviewed on 3/19/24 at 9:33 a.m. The diagnoses included, but were not limited to, Alzheimer's dementia, memory impairment, syncope, and vertigo.</p> <p>A Service Plan, dated 2/2/24, indicated safety maintained by staff assisting with occasional</p>		<p>immediately by the ED on elopement policy. Employee who shut off door alarm received written discipline.</p> <p>2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All staff were educated on elopement. All doors are secure and monitored by maintenance director. Door codes have all been changed for extra level of security.</p> <p>3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All memory care doors will remain armed and locked for the security of the residents. Nursing no longer has access to disarm the alarm. Secured unit exit doors will no longer be used to move furniture in or out- only the front door will be used.</p> <p>4 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; Maintenance director will check all doors 3x/week for 1 month; then 1x/week for 1 month; then 1 time/month as preventive</p>	

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	<p>redirection. Resident B needed staff to assist in maintaining safety by providing Resident B with occasional redirection. Resident B's orientation was severely impairment.</p> <p>A progress note, dated 3/17/24 at 2:35 p.m., indicated Resident B walked outside through the north emergency exit door unassisted. Resident B returned to the facility from the neighbor's house. Resident B was last visualized by staff at approximately 2:25 p.m. Resident B was physically assessed to have an abrasion to right arm and right lower leg.</p> <p>On 3/19/24 at 10:15 a.m., a review of the surrounding area map indicated that to the north Highway 44 (high traffic area) was approximately 800 feet and Interstate 65 (high traffic area) was approximately 0.7 miles to the west.</p> <p>On 3/19/24 at 9:18 a.m., the Administrator provided a copy of a facility policy, dated 11/13/15, titled Elopement or Missing Resident Policy, and indicated this was the current policy used by the facility. A review of the policy indicated it is the policy of the facility to provide a safe environment for all residents.</p> <p>This citation relates to Complaint IN00430745.</p>		<p>maintenance per company policy. Staff will be educated on elopement at each staff monthly meeting for the next 4 months.</p> <p>5 By what date the systemic changes will be complete; 3-18-24</p>	