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	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF BLOOMINGTON	3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401

(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 Complaint IN00411516. Complaint IN00411516 - State deficiencies related to the allegations are cited at R0052. Survey date: June 26, 2023 Facility number: 012706 Residential Census: 22 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed June 29, 2023.	R 0000		
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; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to protect the residents right to be free from neglect for 1 of 3 residents reviewed for elopement. A resident with a history of elopement left the facility without supervision and was found approximately 1.5 miles from the facility by a bystander. (Resident B) Finding includes: During an interview on 6/26/23 at 12:36 p.m., the	R 0052	What corrective actions will be accomplished for those residents found to have been affected by the finding: 1.) All staff in-serviced on community policy of Missing Resident/Wandering Resident. Nursing staff in-serviced on community policy of incident reports and following the	06/27/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhiannon Study	ED	07/28/2023

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	DON (Director of Nursing) indicated, on 6/24/23, she was notified by QMA 1 that Resident B could not be located. During the search for Resident B, the DON was notified by the local police department that Resident B was found approximately 1.5 miles away and was taken to a hospital by a bystander. The DON indicated all of the doors were secured including, the secured front door. The facility suspected Resident B had walked out the front secured door with visitors. During Resident B's admission process, Resident B's son made the facility aware that Resident B eloped from the previous facility. During an interview on 6/26/23 at 1:22 p.m., CNA 1 indicated the visitors are not supposed to have any codes to the doors. There was a button under the desk staff could press to let out the visitors, or staff can type in the code. To prevent residents from leaving, when she saw residents walking close to the doors she stepped in and redirected them, took them to an activity or sit and talk to them. Resident B was exit seeking the day before she left, she was going to the exit doors pushing on them, so CNA 1 took her to her husband's room and explained that her children got her the apartment. During an interview on 6/26/23 at 2:41 p.m., QMA 1 indicated she saw Resident B at approximately 6:30 p.m. walking in the hall. Resident B seemed happy and said hello to QMA 1 and another resident. At approximately 7:00 p.m., QMA 1 went to Resident B's room to administer medication and Resident B was not in her room. Resident B left the facility. The facility was notified that Resident B was at the hospital and was okay. The clinical record for Resident B was reviewed on 6/26/23 at 2:55 p.m. The diagnoses included,		elopement policy/High Risk Elopement Form. Nursing staff audited all medical records to ensure proper diagnosis, which is placed on assessments to ensure accuracy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: 1.) DON and AED will have the community door codes changed immediately to ensure the safety of all residents and continue to monitor the door codes and ensure that no family members will gain access to the codes and change them every 30 days. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 1.) DON will continue to monitor/audit all resident assessments for all new admissions, any/all incidents, changes in condition and semi-annually to ensure on-going compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur: 1.) DON will in-service all nursing	

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	but were not limited to, depression, dementia, and weakness. An elopement risk evaluation, dated 12/1/22, indicated Resident B was at high risk for elopement. A service plan, dated 12/1/22, indicated Resident B had 1 previous elopement (from previous facility) in her history. It had not happened again, however, engage Resident B if she goes to exit doors and ensure and redirect her to a safe place or activity. During an observation on 6/26/23 at 1:00 p.m., the area surrounding the facility was observed. The street was observed to be highly traveled. A timeline of events provided by the Administrator on 6/26/23 at 1:30 p.m., indicated on 6/24/23 at 7:33 p.m., the DON received a phone call from QMA 1 that staff were not able to locate Resident B. At 7:44 p.m., Resident B's son notified the facility that Resident B was located at a round-a-bout near the facility. At 8:10 p.m., a police officer arrived at the facility and notified the facility that Resident B was located by a good samaritan down the road. The good samaritan took Resident B to the hospital after noting confusion. On 6/26/23 at 1:00 p.m., the Administrator provided a copy of a facility policy, titled Elopement Risk Policy and Procedures, dated 3/24/22, and indicated this was the current policy used by the facility. A review of the policy indicated the resident's individualized service plan will contain all interventions, including personalized approaches to prevent an elopement.		staff monthly for 6 months, and immediately upon and new hires on resident assessments for proper diagnosis for new admissions, any/all incidents, changes in condition, review facility policy for elopement, semi-annually to ensure on-going compliance. DON will report any concerns to the AED and will follow recommendations to ensure compliance.	

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	This State tag relates to Complaint IN00411516.			