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	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ANTHOLOGY OF MERIDIAN HILLS	8549 N MERIDIAN STREET INDIANAPOLIS, IN 46260

(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 IN00387612 and Complaint IN00387683. Complaint IN00387612 - Substantiated. State deficiencies related to the allegations are cited at R0052. Complaint IN00387683 - Unsubstantiated due to lack of evidence. Survey date: August 19 and August 22, 2022. Facility number: 013933 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 31, 2022.	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 observation, interview and record review the facility failed to ensure a resident was free from neglect when a resident with dementia wandered away from the facility grounds without the staff's knowledge for 1 of 3 residents reviewed for neglect (Resident B) which resulted in Resident B being transported back to the facility	R 0052	table="" border="1" data-table="" data-tablelook="1184" aria-rowcount="2"> p="" paraid="180792929" paraeid="{91c03b9e-1e45-48b3-95 cd-68c954cd6aab} {108}">Immediate Action Taken:	10/30/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	by his spouse after he was missing for 4 hours, had walked three miles on a busy multiple lane road in a large city, was picked up by a stranger, and transported to his spouse's home. Finding includes: During an observation of the facility grounds on 08/19/22 at 12:35 p.m. it was noted the facility was located at a busy intersection that moved a large volume of traffic in both the east to west and north to south directions. The main entrance was accessible from Meridian Street and the parking lot was accessible from 86th Street. There was a door to the rear of the facility that allowed easy access to 86th Street from the patio area. There was no fence or gate observed. In an interview on 08/19/22 at 12:08 p.m., the spouse of Resident B indicated she was home and heard someone knocking on the door. It was Resident B and an unknown woman who had brought him home. The woman indicated she had found Resident B in a parking lot off 86th Street and Dean Road. Resident B remembered his address and the woman brought him home. The spouse indicated she was stunned. She had not been aware he was missing from the facility. The spouse indicated Resident B did not have any identification on him that day. She did contact the facility and inform them she would be returning him to the facility. She put the time between 3:30-4:30 p.m. In an interview, on 08/19/2022 at 2:10 p.m., the Director of Nursing DON indicated she was not in the facility at the time Resident B wandered out. She was contacted by a staff member and informed of the incident and Resident B was going to be transported back to the facility by his		Assisted living resident was returned to the community by his wife and assessed for injury. LPN assessed for injury. agreed to stay with the resident while the elopement was investigated, and a care plan meeting could be held. PCP notified. Immediate Inservice for all staff on missing resident policy. All alarms were tested and working correctly. p="" paraid="1814304863" paraeid="{91c03b9e-1e45-48b3-95 cd-68c954cd6aab}{168}">Audit: All door alarms were inspected and working correctly. for alarm failures were reviewed. All residents that wear Wander Guards were re assessed to determine appropriateness or correct placement Systemic Updates: All residents were educated on the importance of not propping doors open. Residents that meet memory care requirements are transitioning to memory care. Residents will be assessed for wandering or risk of elopement every 6 months or upon change of condition. Community retired the use of the wander guard system. Monitoring of Action Plan: Care staff team (QMA) will monitor the placement of active wander guard device (for those residents with such) daily or until removed by assessment. The Director of Health and Wellness and/or designee will monitor QMA verification of wander guard	

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	spouse. She indicated it was about 3:00 p.m. Per the facilities investigation it was believed Resident B left the facility at about 11:00 a.m., because that was the time the door alarm sounded per the door tracking system. She believed someone turned off the alarm without checking the immediate area. Facility staff did not search for the resident. She arrived at the facility about 5:00 p.m. and then assessed the resident for injury. The resident did have a "light" sunburn on the tops of both feet as he had been wearing open toe shoes/sandals. In an interview on 08/22/22 at 10:26 a.m., the Director of Nursing indicated she did not expect a resident with a diagnosis of dementia to remember to sign out or tell staff if they were leaving the building. In an interview on 08/22/22 at 10:43 a.m., the Activity Director indicated the last time she saw Resident B on the day he left the facility was about 10:30 a.m. when he came for an exercise activity which he did not like. He stayed about 10 minutes then left. She then saw him about 11:00 a.m. walking towards the elevator and thought he was going to lunch since it was about time for lunch. In an interview on 08/22/22 at 11:36 a.m., Qualified Medication Assistant (QMA) 1 indicated anyone with a wander guard that passes the door to the employee lot will set off the alarm. She did respond to the alarm and there was no one by the door. She went out and looked in parking lot, courtyard (back entrance), and down 86th street and did not see anyone. She turned off the alarm. She did head count on the first floor which consisted of taking the resident list and checking the rooms to make sure all residents in the		placement each week until all residents that are transitioning to Memory care have done so or wander guard was removed. Wander guard placement will be appropriately documented within the resident file. Policy review was completed with a focus on of a headcount when an elopement occurs. Elopement drills will be completed every 6 months. p="" paraid="569606630" paraeid="{1ef7f944-dcb3-4734-ad1a-e9f2e6e3b967}{22}"> p="" paraid="1681276877" paraeid="{1ef7f944-dcb3-4734-ad1a-e9f2e6e3b967}{75}">	

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	building. Then she passed the paper on to the next shift and informed them of the incident. She accounted for all the first-floor residents only. In a telephone interview on 08/22/22 at 11:51 a.m., the second floor QMA 2 indicated she was not aware of Resident B leaving the facility until about 3:00 p.m. when she was called and informed, she had left early that day to go to the physician. She did not hear any alarms and she was not told about any alarms sounding. In an interview on 8/22/22 at 12:35 p.m. the Director of Nursing, after reviewing the elopement alarm log, indicated the alarm, which sounded at 10:54 a.m., was not responded to timely and the policy for elopement was not properly implemented. She was also unable to locate a letter written by the physician regarding a resident with dementia leaving the building unaccompanied. The record for Resident B was reviewed on 08/22/22 at 9:14 a.m. Diagnoses included, but were not limited to, dementia and pulmonary embolus. A nursing note, dated 08/09/22 at 10:45 p.m., indicated Resident B exited the patio door from the facility's patio door off the dining room. The resident was wearing a wander guard (an alarm system) that was in place and working properly. Another resident had propped the door open to walk her dog and return without having to ask for staff assistance. Resident B had walked to a gas station, and someone observed he was looking for help, so they asked him for his address and then drove him to his prior home. Resident B's spouse was home and met him. She called the facility to alert them the resident had left, and she was returning him.			

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	A facility document, provided by the Director of Nursing on 08/22/22 at 11:34 a.m., titled, "Elopement Alarms," indicated an elopement alarm sounded on 08/05/22 at 10:54 a.m. at the East Parking Lot Entrance. The alarm was acknowledged in 5 minutes and 8 seconds. The response time was 41 minutes and 23 seconds. The alarm was resolved by QMA 1. A facility policy, revised on 02/2022, provided by the Director of Nursing on 08/22/22 at 10:32 a.m., titled, "Clinical 10-Elopement," indicated, "...If the resident has a diagnosis of dementia...Resident's will be provided with Community business cards to keep in the purses or wallets...a physician's statement regarding leaving the building unescorted will be obtained...Should an elopement occur, an immediate systematic search of the property and surrounding neighborhood will take place...." This State Residential Finding relates to Complaint IN00387612.			