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	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DIGBY PLACE	167 CR W 240 S LAFAYETTE, IN 47905

(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 IN00435149. Complaint IN00435149 - State deficiencies related to the allegations are cited at R0052 Survey dates: May 29 and 30, 2024 Facility number: 004392 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 5, 2024.	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 protect a resident from neglect, when the resident exited the facility through an unlocked kitchen door, without staff knowledge, was gone for an undetermined length of time, and was found behind the facility in the middle of the night, on 5/22/2024. (Resident B) Finding includes: An Indiana State Department of Health Intake	R 0052	R 0052- Resident rights 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Upon return to the community on 5/22/2024, the resident was placed on frequent checks and her	05/30/2024

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

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	Information Form, dated 5/22/24, indicated the resident had eloped out of the facility and was returned to the facility by the local police at 3:30 a.m. Reports indicated she left the facility through the kitchen door. The clinical record for Resident B was reviewed on 5/29/24 at 1:04 p.m. The diagnoses included, but were not limited to, cerebral vascular accident (CVA), hypertension, and Parkinson-like symptoms. The service plan for Resident B, last updated on 2/12/24, indicated the resident had no wandering behaviors, could communicate independently, was independent in activities and socialization behaviors, and was independent in mobility. The resident utilized a walker for mobility and was at risk of falling. A nursing progress note, on 5/22/24, indicated the resident was returned to the facility at 3:30 a.m., and 1:1 observation was started. Resident B indicated to the staff; she was walking to find someone to help her with something she needed to do. The resident was unable to remember what she wanted done. The resident indicated she went through the kitchen door to leave. A mini mental assessment was completed and indicated a decline in the resident's mental status. The resident had a score of 18 and her previous score was 26. A police report, dated 5/22/24, indicated the resident was found at a nearby residence (GPS indicated the residence was 0.6 miles from the facility). The report indicated a call was made to the police department regarding the resident who had been on the porch sitting for about an hour at the residence. The police contacted the family and		MD was notified of her increased confusion. Maintenance was called to the community to repair the alarm to the kitchen delivery door. The alarm was repaired on 5/22/2024 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: Elopement assessments and updated SLUMS were completed for the entire community by the DHW and ED. All residents with the potential for elopement were added to the Elopement binder with their picture, date of birth and room number. The binder is accessible to all staff and located at the clock in area. Elopement inservicing was done with all employees, as well as inservicing on locking the kitchen door for the night following completion of the evening meal. 3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Evening staff will lock the kitchen door after completion of the evening meal nightly and sign off	

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	found the resident's address to be the facility. The resident was returned to the facility at 3:30 a.m. The area around the facility was observed, on 5/29/24 at 10:31 a.m., at the side of the facility was a paved road which led to a steep downgrade of grassy area which led into the housing area where the resident was found. During an interview, on 5/29/24 at 12:40 p.m., the resident's son indicated he was called by the police and notified of his mother's elopement from the facility. His mother had become more confused lately in conversations with him. She had been tested for a bladder infection. The resident would get more confused when she had an infection. He did not know why or how his mother was able to elope from the facility in the early morning hours of the day. During an interview, on 5/29/24 at 11:30 a.m., the Director of Nursing (DON) indicated the door to the exit the facility in the kitchen was not alarmed for egress. The entrance door to the kitchen from the dining area was not locked at night. The resident told her she thought she left out the kitchen door of the facility when she left on 5/22/24. The resident was returned to the facility at 3:30 a.m. The resident's mini mental score after her return to the facility went from 26 to 18. The DON notified the physician of the change in the resident's mini mental score, asked for a diagnosis of dementia and requested a urinalysis for a possible urinary tract infection (UTI). The resident was more confused when she had a UTI. During an interview, on 5/29/24 at 2:42 p.m., staff member 6 indicated she was working on 5/22/24, when Resident B was returned to the facility by the police at approximately 3:30 a.m. The facility		on completion. Maintenance will conduct weekly alarm tests of all exit doors and sign off on completion. 4. How the corrective action will be monitored to ensure the deficient practice does not recur: ED or designee will review all sign off logs daily x4 weeks, then biweekly for 4 weeks, then weekly ongoing. Compliance will be discussed in monthly QI meeting ongoing. Quarterly elopement drills will be completed per policy, ongoing. 5. By what date will the systemic changes be completed: All systemic changes will be completed by 6/30/2024 We request an IDR for this tag, as all necessary items have been completed and documented	

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	had been called by the police and notified the resident was found a block away from the facility. The staff member was not aware the resident had left the building and had last seen the resident at 1:30 a.m. The resident had been up and walking throughout the facility since she could not sleep. She indicated she was not aware if the kitchen doors were locked in the evening. During an interview, on 5/29/24 at 3:29 p.m., staff member 4 indicated the resident was confused when she had a UTI which was often. The resident did walk the hallways throughout the day, but she had never been exit seeking. She was not aware if the kitchen was locked in the evening. During an interview, on 5/29/24 at 3:10 p.m., staff member 7 indicated the back door to the parking lot was not alarmed and the kitchen doors from the dining area through the kitchen to the outside door were not locked in the evening. A facility policy, titled "Elopement or Missing Resident Policy," dated as effective 7/1/23 and received from the Director of Nursing on 5/30/24 at 12:18 p.m., indicated "...A resident is considered missing when he or she leaves the community undetected and without notice to the community by writing in the Sign-out Log or notification by the annunciator attached to exit doors within the community...." This citation relates to Complaint IN00435149.			