STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave Indianapolis, IN 46222

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on interview and record review, the facility failed to ensure the need for specialized services in regard for the need of a secured unit for placement for 1 of 5 residents reviewed for discharge. (Resident H) Findings include: The clinical record for Resident H was reviewed on 7/11/22 at 3:55 p.m. The diagnoses included, but were not limited to, schizoaffective disorder (bipolar type), anxiety disorder, major depressive disorder, and dementia. He was admitted to the facility on [DATE]. A Brief Interview for Mental Status (BIMS) score, from previous facility, dated 3/28/22, indicated Resident H was cognitively intact. A Wandering/Elopement Risk assessment, dated 5/30/22, was conducted at his previous facility. Resident H was noted to be at risk to wander. A Wandering Risk Scale assessment, dated 6/30/22, indicated Resident H could follow instructions, was ambulatory, had no history of wandering, had NO diagnosis of dementia/cognitive impairment. This calculated his score to be low risk. An Elopement Risk Review, dated 6/30/22, indicated no diagnosis of dementia, did not pace or wander, no attempt to get outdoors, no history of elopement, and he did accept nursing home placement. This calculated his score to be not at risk. (continued on next page)

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

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Executive Director (ED), on 7/11/22 at 2:33 p.m., indicated she received a referral for Resident H via fax and e-mail from (name of previous facility). She then reached out and spoke to a Social Worker to ask what was going on with Resident H because he was located a long distance from here. She was informed that Resident H was younger, and he needed more activities. The ED asked about his diagnosis of dementia, but she was informed that his BIMS (Brief Interview for Mental Status) was 14 (meaning cognitively intact). There was nothing in his profile that was different than what she was told over the phone. She usually requested the residents' medication listing, history/physical, and progress notes. She likes to attempt to reach out to a family person to start building a relationship process and bring them up to speed on the process. It was attempted but it was not fulfilled. The (name of previous facility) transported him to this facility. She felt like she wasn't made aware of Resident H's status as a whole. If she did know his full status, she would not have accepted him into the facility. It was not shared with her that Resident H resided on a secured unit at the previous facility. The ED commented that a face-to-face interview and/or observation was not conducted of Resident H prior to admission to the facility. There was no secured unit at this facility. A policy titled Admission Guidelines, dated 1/1/17, was provided by the ED on 7/13/22 at 9:58 a.m. The policy indicated the following, .All applicants for admission will be individually assessed for reasonable accommodation .The pre-admission evaluation of each prospective resident must ensure that only those individuals are admitted whose medical/psychosocial needs can be met by the facility .Procedure .1. An evaluation of each resident shall be made, prior to admission, which shall include personal or telephone interviews with the resident, the resident's physician, or the representative of the facility from which the resident is being transferred, if applicable This Federal tag relates to Complaint IN00384913. 3.1-15(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on interview and record review, the facility failed to ensure adequate supervision was in place when a resident with dementia (Resident H) exited the facility on 7/4/22 without supervision through an unknown point of exit. The resident was picked up by local police and was found walking along the interstate on 7/5/22 in the afternoon. This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy began on 7/4/22 when a resident with dementia (Resident H) exited the facility without facility knowledge. The Executive Director (ED), Regional Director of Operations (RDO), Director of Nursing (DON), and Regional [NAME] President (RVP) were notified of the Immediate Jeopardy on 7/12/22 at 2:35 p.m. Findings include: The clinical record for Resident H was reviewed on 7/11/22 at 3:55 p.m. The diagnoses included, but were not limited to, schizoaffective disorder (bipolar type), anxiety disorder, major depressive disorder, and dementia. He was admitted to the facility on [DATE]. A Brief Interview for Mental Status (BIMS) score, from previous facility, dated 3/28/22, indicated Resident H was cognitively intact. A Wandering/Elopement Risk assessment, dated 5/30/22, was conducted at his previous facility. Resident H was noted to be at risk to wander. A Wandering Risk Scale assessment, dated 6/30/22, indicated Resident H could follow instructions, was ambulatory, had no history of wandering, had no diagnosis of dementia/cognitive impairment. This calculated his score to be low risk. An Elopement Risk Review, dated 6/30/22, indicated no diagnosis of dementia, did not pace or wander, no attempt to get outdoors, no history of elopement, and he did accept nursing home placement. This calculated his score to be not at risk. There was no care plan in place for elopement risk due to Resident H not being identified as an elopement risk. A physician order, upon admission to the facility, indicated Resident H could go on a leave of absence (LOA) with family or responsible party. An activities of daily living (ADL) care plan, dated 7/1/22, indicated Resident H required staff assistance with ADLs due to debility and poor activity endurance. A fall care plan, dated 7/1/22, indicated Resident H was at risk for falls with potential for injury related to weakness, dementia, anxiety, and pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 7/4/22 at 11:17 p.m., indicated the following, .Writer noted during start of shift rounds that he [Resident H] was not in his room. all staff on duty informed to check every room, bathroom and open door inside facility, writer walked the facilities outside parameter [sic], checked 2 nearest gas stations and [name of fast-food restaurant], he was not seen, ED [Executive Director] notified of missing resident The investigative file was reviewed on 7/12/22 at 10:45 a.m. A statement from Qualified Medication Assistant (QMA) 2, dated 7/4/22, indicated she did not let any residents out of the facility but when she went to the parking lot there were residents out front watching fireworks. She wasn't sure how the residents got outside or what staff was watching them. A statement from Resident B, dated 7/5/22, indicated he was outside without staff present and a black lady let him out that was probably staff. States he was there for 20 minutes, and he saw Resident H leave and go left on (name of street facility is on). Staff brought Resident H back in when identified missing resident. A statement from QMA 3, dated 7/5/22, indicated at approximately 10:00 p.m. she had seen 4 residents coming up the middle hallway. A resident told her they were outside watching fireworks. None of these residents were Resident H. A statement from Registered Nurse (RN) 4, dated 7/5/22, indicated he last saw Resident H between 7:00 p. m. and 8:00 p.m. when he gave Resident H's roommate medications. When RN 4 went outside for a smoke break, at 10:25 p.m., he went towards the front of the facility and saw (names of 6 residents) entering the facility through the front door. There were no staff seen outdoors. A statement from Licensed Practical Nurse (LPN) 5, dated 7/4/22, indicated another resident (Resident J) mentioned seeing Resident H wearing a baseball cap, glasses, white t-shirt, and blue jeans walk off the facility premises. A statement from Certified Nursing Assistant (CNA) 6, dated 7/4/22, indicated she conducted a walking report during shift change. She recalled Resident H lying in bed looking at the window at that time. This would have occurred between 10:56 p.m. and 11:00 p.m. per the ED. An article from a local news station, published 7/5/22, indicated the following, .[name of Resident H] was last seen Monday, July 4 after watching fireworks .Police say Tuesday afternoon that he had been located and is safe An interview conducted with Family Member 12, on 7/11/22 at 2:14 p.m., indicated a police officer showed up to her front door on 7/5/22 at 3:30 a.m. She was informed that Resident H was missing, and they were in the process of searching for them. She was then later informed Resident H had been found walking along the interstate and was missing all night long. He had eloped at a previous facility he was at and resided on a secured unit. She was not aware that Resident H was going to a facility that didn't have a secured unit for him to reside in. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview conducted with the ED, on 7/11/22 at 2:33 p.m., indicated she received a phone call on 7/4/22 at 11:17 p.m. that Resident H could not be found. After conducting an investigation, I was told there was a resident, Resident J, that would watch the receptionist leave and observe them punch the code to the front door. That's how he was able to retrieve the code to the front door. She believes it was around 8:30 p.m., to when the group of residents went outside to watch the fireworks. She was unable to recall the time Resident H was found by police. He was found walking along the interstate by the local police and then transferred to a local hospital. He remains there until they can find the best placement for him. An interview conducted with Resident K, on 7/12/22 at 11:30 a.m., indicated that she saw fireworks from a window inside the facility around 9:00 p.m. on 7/4/22. She and a few other residents decided to sneak out. There was a resident, Resident J, who knew the code to the front door. We all sat outside and watched the fireworks. She didn't recall seeing Resident H while she was outside. She mentioned there were concerns in the past with facility staff propping the side door open with a rock when they go outside to smoke. When the management staff leave for the day the nursing staff will prop the door open and leave it open. She mentioned that's probably how he got out. She was referring to Resident H. An interview conducted with RN 4, on 7/12/22 at 1:00 p.m., indicated he administered medications to Resident H between 7:45 p.m. and 8:00 p.m. on 7/4/22. The shift before him didn't mention any risk factors about Resident H. He conducted a walkthrough every 1-2 hours and he never observed Resident H outside of his room. An interview conducted with the ED, on 7/12/22 at 12:19 p.m., indicated Resident J commented about pressing the code pad once to the front door. She was unable to confirm if the residents had walked out after a staff member because Resident J was in a wheelchair and unable to hold the door open for others to exit. Resident J then commented about other residents coming outside behind him. The receptionist had left at 7:00 p.m. on 7/4/22. Resident J mentioned he would closely watch the staff press the touch pad to obtain the code to the front door. He never confirmed that he let anyone out because the other residents came behind him. She was unaware of any staff members propping the door open to the staff smoking area. There was a camera present to that location but there had been concerns recently regarding the camera being manually unplugged frequently. A policy titled Policy and Procedure Regarding Missing Residents and Elopement, undated, was provided by the RDO on 7/11/22 at 4:00 p.m. The policy indicated the following, .It is the policy of the facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs. All residents will be assessed for behaviors or conditions that put them at risk of elopement. All residents assessed to be at risk of elopement will have this issue addressed in their plan of care .Procedure for the Prevention of Missing Residents .1. All residents shall be assessed for behaviors that place them at risk of elopement utilizing an elopement risk assessment upon admission .4. Unless otherwise identified in a plan of care, any resident at risk of elopement shall be accompanied by a responsible individual while outside the facility The Past Noncompliance Immediate Jeopardy began on 7/4/22. The Immediate Jeopardy was removed and corrected on 7/7/22 when the facility completed elopement assessments for all residents, door checks and audits implemented, changed door codes, staff education on securement of doors, elopement drill conducted, and ensuring all exit doors always remain secure. The correction date was prior to the start of the survey and was therefore Past Noncompliance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3.1-45(a)(1) 3.1-45(a)(2)