STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOREST CREEK VILLAGE	**525 E THOMPSON RD INDIANAPOLIS, IN 46227**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **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** Based on observation, record review, and interview, the facility failed to ensure a severely cognitively impaired, fall risk, and elopement risk resident who resided on the Memory Care Unit was supervised while in the outside courtyard area for 1 of 3 residents reviewed for supervision to prevent accidents. (Resident B) Findings include: The clinical record of Resident B was reviewed on 7/8/20 at 11:45 a.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED].it is clinically indicated that the resident reside on a secured unit, resident may engage in therapeutic, structured work activities . The significant change MDS (Minimum Data Set) assessment, dated 6/5/20, indicated Resident B was severely cognitively impaired. A care plan, dated 9/13/18 and current through 4/12/20, indicated .Resident is at risk for elopement per the Elopement Risk Assessment as evidenced by dx (diagnosis) of dementia and history of exit seeking. Approach: all facility exits secured, Resident resides on a secured unit . A care plan, dated 7/6/18 and current through 4/12/20, indicated Resident resides on a secured memory care unit .Goal: Resident will benefit from structured program and secured environment .Approach: keep environment free from hazards . A care plan, dated 7/2/18 and current through 2/12/20, indicated .Resident is at risk for falls due to: .dx of DM 2, [MEDICAL CONDITIONS] with shortness of breath, needing assistance with his ADLs (activities of daily living), high risk of fall medications for depression and [MEDICAL CONDITION], difficulty walking with causing restricted mobility and previous fall history and muscle weakness .has [MEDICAL CONDITION] and hallucinations that effect his visual field; altered awareness of immediate physical environment impulsive and lack of understanding on one's physical and cognitive limitations .cognitive loss due to dementia, slight immobility .Goal: resident fall risk factors will be reduced in an attempt to avoid significant fall related injury . The MatrixCare-Johns Hopkins Fall Risk Assessment Tools, dated 6/4/20 and 7/6/20, indicated Resident B was a Moderate Fall Risk. An Elopement Risk Assessment, dated 4/29/20, indicated .Resident has the ability to move about freely and easily which would allow the resident the capability of leaving the facility unassisted; Resident exhibits significant cognitive impairment that impacts elopement risk (i.e. consider and assess disorientation to surroundings, poor decision making abilities .Resident is at risk of elopement . On 7/8/20 at 4:00 p.m., the Memory Care Unit's surveillance footage for 7/2/20 to 7/3/20 was reviewed with the DON (Director of Nursing) and ADM (Administrator). The following was observed on the surveillance footage: -At 5:23 p.m., Resident B exited the Memory Care Unit through the door of the dining room area and entered the enclosed courtyard area. Resident B turned right and walked out of camera range. No staff were observed. -From 5:24 p.m. to 6:14 p.m., Resident B was not visible on the surveillance footage. No staff were observed entering or exiting the courtyard. -At 6:15 p.m., Resident B entered the Memory Care unit through the door of the dining room area from the enclosed courtyard area. No staff were observed. -At 8:49 p.m., Resident B exited the Memory Care Unit through the door of the dining room area and entered the enclosed courtyard area. Resident B turned right and walked out of camera range. No staff were observed. -From 8:50 p.m. to 9:54 p.m., Resident B was not visible on the surveillance footage. No staff were observed entering or exiting the courtyard. -From 9:55 p.m. to 10:06 p.m., Resident B walked to the door of the dining room area and peered into the glass of the dining room door while still in the courtyard area. No staff were observed. -At 10:07 p.m., Resident B turned to the right, walked away from the dining room door inside the enclosed courtyard area, and walked out of camera range. No staff were observed. -From 10:07 p.m. to 7/3/20 at 12:40 a.m., Resident B was not visible on the surveillance footage. No staff were observed entering or exiting the courtyard. -At 12:41 a.m., RN (Registered Nurse) 2; CNA (Certified Nursing Assistant) 3; and CNA 4 exited the Memory Care Unit through the door of the dining room area and entered the enclosed courtyard area. At that time, Resident B walked within camera range toward staff. -At 12:42 a.m., Resident B, RN 2, CNA 3, and CNA 4 enter the Memory Care unit, through the door of the dining room area, from the enclosed courtyard area. On 7/9/20 at 9:15 a.m., during a tour of the Memory Care Unit courtyard area with the ADM and DON, the following was observed: -The exit door, which was punch key coded in order to open the door, from the dining room area into the courtyard. Taped to the dining room door (facing inside the room) was a bright orange sign which indicated, RESIDENTS MUST BE ACCOMPANIED BY STAFF OUTSIDE IN THE COURTYARD AT ALL TIMES. During an interview, at that time, the ADM and DON indicated all residents must be accompanied by staff when outside. -Once outside, a surveillance camera was observed above the door. During the tour, the ADM indicated the surveillance camera was directed toward the door and did not capture the rest of the courtyard area. -The courtyard area was enclosed by a white 6 foot vinyl fence and had a concrete side walk that divided the courtyard. There were 2 chairs and a love seat 15 feet to the right of the dining room door. Another sitting area was observed just beyond the first sitting area. The sitting areas did not provide protection from the elements. Beyond the sitting areas were flowers, shrubs, and other greenery surrounded by uneven ground covering. There were 2 yard lights observed near the two sitting areas. During the tour, the ADM indicated the yard lights dimly lit the sitting area only. On the left side of the courtyard area were flowers, shrubs and other greenery surrounded by uneven ground covering. At the end of the courtyard, 40 feet from the dining room door, was a door that opened into the maintenance shop. No light fixtures were observed in the area. Interview, on 7/9/20 at 10:10 a.m., QMA (Qualified Medication Aide) 5 indicated on 7/2/20 she had worked the evening shift on the Memory Care Unit. Resident B requested to sit in the Memory Care Unit courtyard twice that evening. He was in the courtyard unattended by staff from around 5:30 p.m. to 6:15 p.m. and then again went outside around 8:45 p.m. She was unsure when he returned inside the building. QMA 5 indicated she was unaware residents were not to be left unattended in the courtyard. Interview, on 7/8/20 at 6:50 p.m., CNA 4 indicated she was unable to locate Resident B when she arrived on the Memory Care Unit close to 1:00 a.m. on 7/3/20. Resident B was located, alone in the Memory Care Unit courtyard. Interview, on 7/8/20 at 2:15 p.m., RN 2 indicated on 7/2/20 at 11:30 p.m., CNA 3 was unable to locate Resident B and notified RN 2. Resident B was found in the Memory Care Unit courtyard shortly before 1:00 a.m. on 7/3/20. RN 2 indicated he thought staff had let Resident B go outside in the courtyard area; he was unsure how long the resident had been outside without supervision. Interview, on 7/8/20 at 3:00 p.m., the DON indicated on 7/2/20, Resident B was in the Memory Care Unit courtyard with no staff in attendance. All residents were to be supervised when in the courtyard. Interview, on 7/9/20 at 10:00 a.m., the DON indicated the facility lacks a policy regarding resident supervision when outside and lacks a specific policy regarding preventing accidents. On 7/8/20 at 10:50 a.m., the DON provided a copy of the American Senior Communities Elopement Prevention and Response Program, dated October 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, .it is the policy of the facility that staff who have residents under their care are responsible for knowing the location of those residents . This Federal tag relates to Complaint IN 126. 3.1-45(a)(2)

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