STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00366601 and IN00367133. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00366601 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00367133 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 16, 17, and 18, 2021 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 128 Total: 128 Census Payor Type: Medicare: 15 Medicaid: 108 Other: 5 Total: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/22/21.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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

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F 689	Continued From page 1 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to implement adequate supervision measures to prevent a cognitively impaired resident from exiting the building. The resident left the building unattended around 7:45 p.m. on 11/3/21 wearing pajamas and socks and was overheard knocking on the door he exited from 50 minutes later. The resident was assessed upon his return and transferred to the facility's secure unit. The facility is located within 1 mile of a major interstate and adjacent to a busy 2 lane road. (Resident B) The immediate jeopardy began on 11/3/21 when the resident had exited the facility without supervision or knowledge of facility staff. The resident was able to exit from the North door. The door was not completely closed even though the key pad indicated the lock was engaged. The door did not have an alarm at that time. The resident was overheard knocking on the same door he exited from 50 minutes later. The resident was assessed upon his return and transferred to the facility's secured unit. The Administrator and Director of Nursing were notified of the immediate jeopardy at 3:04 p.m. on 11/16/21. The immediate jeopardy was removed, and the deficient practice corrected on 11/10/21 prior to the start of the survey and was therefore Past Noncompliance.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

Finding includes:

The record for Resident B was reviewed on 11/16/21 at 9:26 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, malignant neoplasm of brain, type 2 diabetes, mild protein-calorie malnutrition, lack of coordination, palliative care, and psychoactive substance abuse. The resident was admitted to the facility on 9/14/21.

The Admission Minimum Data Set (MDS) assessment, dated 9/21/21, indicated the resident was cognitively impaired for daily decision making. The resident had no episodes of wandering and required extensive assistance with one person physical assistance for locomotion on and off of the unit.

The elopement risk assessment, dated 9/14/21, indicated the resident was not at risk to elope at the time, placement on the elopement risk protocol was not indicated.

The resident had no Care Plan related to wandering based on the Admission MDS and elopement risk assessment.

Nurses' Notes, dated 11/3/21 at 8:21 p.m., indicated "the CNA came to nursing station and state [sic] resident was knocking on the B wing exit door with no shoes on and leaves all over his body, hands cold, but no apparent injuries to body, resident asked why was he outside, state [sic] he did not know, resident have [sic] been confused since his transfer from south unit, resident unable to find the bathroom, resident would go to closet and urinate or defecate there, poor historian, Administrator called and informed

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F 689	Continued From page 3	F 689		

of situation, state [sic] to move resident to BHU [behavior health unit] DON [Director of Nursing] called and informed of situation state [sic] to do urine c&s and sent to lab. Evening supervisor also notified, transferred resident to BHU per wheel chair in good condition."

According to www.weather.com, the local temperature was 36 F at 7:45 p.m. on 11/3/21.

Interview with the Administrator on 11/16/21 at 9:37 a.m., indicated the resident left the facility around 7:47 p.m. on 11/3/21 and returned on his own approximately 50 minutes later. He was last seen inside the facility at approximately 7:30 p.m. An investigation was initiated and the incident was reported to the Indiana Department of Health (IDOH). The Administrator indicated the resident was observed on the camera exiting the door on the middle hall of the North Unit. The resident was residing in Room 115 at the time which was approximately 10-15 feet from the exit door. The resident was observed pushing an overbed table in the hall. The table bumped against the door and the door opened due to the door not being latched securely and locked. There was no 15 second delay release for the door and/or alarm. There was a keypad on the door to get out, the Administrator indicated the red light on the key pad was on, which should have meant the door was locked. The code to get out was the month and year which all staff knew. The Administrator also indicated she did not feel the resident was actually exit seeking, the door opened when the table hit it.

When the resident returned, he was assessed and moved to the secured unit. The resident had no previous elopement attempts. The

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F 689	Continued From page 4	F 689		

Administrator indicated she immediately changed the code to the door, management staff received the code to the door, and a sign was posted on the door to no longer use the door as an entrance or exit unless it was an emergency.

Observation of the North exit door on 11/16/21 at 9:45 a.m. with the Administrator, indicated there was a key pad lock along the door frame and a magnetic lock in the top right hand corner of the door. The Administrator pushed on the door and the door would not open. When she put the code in on the key pad, the door opened and the alarm also sounded. Staff in the area looked down the hall in response to the alarm.

Further interview with the Administrator at 10:16 a.m., indicated staff did not know the resident was missing due to the door did not alarm when it was opened. She indicated the resident knocked on the same door he exited 50 minutes later. She felt he stayed in the same area the whole time he was outside due to his reflection being seen on the outside camera from time to time. As soon as the resident was brought inside, she was notified as well as the resident's Physician and family. He was assessed and moved to the secured unit. A facility wide head count was also completed.

Review of facility investigation and elopement timeline, indicated the resident exited the building through the North door. He was gone approximately 50 minutes. He was observed with a dark green sweatshirt, flannel pajama bottoms, and non-skid socks. The resident was assessed by the RN and his vitals were normal including body temperature. He had an elopement risk assessment completed, and he was moved to the

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F 689	Continued From page 5	F 689		

facility's secure unit. Family and Physician were notified of the outcome of the investigation. Assessments and care plan updated. The facility checked the North door several times and were unable to open the door without a code. Code changed by facility. Safe Care was contacted on 11/4/21 to determine if the door magnet was faulty and how the resident exited the door. On 11/8/21, Safe Care determined the swing door needed adjustment and small particles of debris needed to be removed from the outside of the door near the door sweep. The door magnet and the keypad were in working order. An alarm system was added to the door per facility request on 11/9/21. Door checks were completed on the North door as well as all doors in the facility until Safe Care made their service call. Daily door checks were also added to the preventive maintenance log.

Per the Leadership team, the root cause of the malfunction of the door was determined to be: a staff or resident exited out of the North door, and when the door closed it did not magnetize or latch securely, however, the key pad light had turned red to indicate the door was locked.

An elopement policy, provided by the Administrator on 11/17/21 at 10:44 a.m., indicated "All personnel are responsible for reporting a cognitively resident [sic] attempting to leave the premises, or suspected of missing, to the Charge Nurse as soon as practical. This includes any resident that did not sign out on pass and/or did not notify a staff member of his or her leaving."

The past noncompliance immediate jeopardy began on 11/3/21. The immediate jeopardy was removed and the deficient practice corrected by

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F 689	Continued From page 6 11/10/21 after the facility implemented a systemic plan that included the following actions: the resident was transferred to the facility's secured unit and reassessed for elopement, the code to the North door was changed, daily door checks were completed, elopement drills were initiated and risk screenings were started for all residents, all staff were inserviced related to the elopement policy, Safe Care was called to assess the doors and ensure they were in working order, an alarm was added to the North door, and Root Cause analysis was started with the Management team. Photographs and resident information for residents at risk for elopement will be kept at the Nurses' Station and Reception Desk. Staff were interviewed and able to explain the policies and procedures. Binders were located at the Nurses' Desk and Receptionist Desk, which included the other residents who were at risk for elopement. This Federal tag relates to Complaint IN00366601. 3.1-45(a)(2)	F 689		