STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1019 BELLE'S PLACE OF WABASH	3037 W DIVISION RD, WABASH, , 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00360399. Complaint IN00360399-Substantiated. State deficiency related to the allegation is cited at R0052. Survey date: August 19, 2021 Facility number: 003466 Residential Census: 23 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on August 25, 2021	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	Statement of Correction: R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents'	09/05/2021

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a confused resident received the supervision to prevent elopement from the facility for 1 of 3 residents reviewed for risk of elopement. This failure resulted in the resident being without supervision, having a fall with injury and being sent to the emergency room with a fractured wrist. (Resident B) Findings include: The clinical record for Resident B was reviewed on 8/19/21 at 9:12 a.m. Diagnoses included, but were not limited to, chronic anemia, diabetes mellitus, dementia, and depression. A fall risk assessment, dated 7/7/21, indicated the resident was at moderate risk for falls. A Global Deterioration Scale (GDS) assessment, dated 7/7/21, indicated the resident had moderate cognitive decline. A service agreement, dated 7/8/21, indicated the resident		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. This RULE is not met as evidenced by: R 052	

	enjoyed sitting outside unattended in the courtyard. The resident also needed reminders for exiting in the event of an evacuation and wore a personal watch. An order, dated 7/15/19, indicated the resident may have a WanderGuard in place. A progress note, dated 8/14/21, indicated the resident was sitting on the back porch for 2 hours when someone knocked on the door and said a lady was on the ground. Two CNAs checked and realized it was the resident who was on the porch. Her wrist looked out of place. Her blood pressure was 151/82, pulse 101 and oxygen saturation was 97%. A CNA checked the back gate and found it unlocked and it was confirmed the resident had walked out of the unlocked gate. An untimed progress note by CNA 3, dated 8/14/21, indicated the resident was sitting on the porch and then a guy who was running knocked on the door and said he saw a woman fall. The CNA asked the resident how she got out and the resident indicated she walked out through the gate. Another aide ran back into the facility to notify the QMA and get items to obtain her vital signs. Her wrist was out of place. They walked to the front porch when the		Based on interview and record review, the facility failed to ensure a confused resident received the supervision to prevent elopement from the facility for 1 of 3 residents reviewed for risk of elopement. Director, or other designated staff member, will re-educate all staff regarding Residents Right for safety. Courtyard gate is to be checked at the beginning of each shift and indicated on check off sheet that the courtyard gate is locked properly. Anyone entering or exiting the courtyard gate will utilize PRN daily check off sheet to indicate gate is locked. Patio doors will be locked between the hours of 8:00 pm and 8:00 am daily. Any resident with GDS of 4 or greater, or who is	

paramedics arrived and took her to the hospital. The resident returned to the facility with a brace on her wrist. The gate had been unlocked by someone other than the other aide or QMA because they had not left the building.

An untimed progress note by QMA 2, dated 8/14/21, indicated the resident was sitting on the porch during medication administration. The QMA decided to leave the resident on the porch because the resident did not want to come in for dinner. A man then knocked on the door and said there was a lady outside that had fallen. One aide went out to get vital signs and to make sure she was okay, and the other aide went to see where she had gotten out of the facility. While on the phone with the Administrator, the aide indicated the gate was unlocked. She attempted to notify the family and then called Emergency Medical Services (EMS). EMS arrived and assessed the resident and transferred her to the hospital around 8:20 p.m. The family returned her call and then showed up at the facility. Resident B returned to the facility around 10:00 p.m. with a broken wrist and a brace on her right wrist.

A progress note by the Administrator, dated 8/14/21 at

wearing a personal watch (Wander Guard) will be supervised at all times while outdoors. All residents with GDS of 4 or greater will have personal watch initiated upon move in and each resident with a watch will be checked each shift for watch placement. Maintenance personnel will check all exit doors weekly using personal watch to insure proper functioning of doors. Maintenance personnel will check courtyard gate weekly to insure gate is locking and functioning properly. Check off sheet to be updated weekly per maintenance personnel and/or designee. Director or designee to check courtyard gate audit sheets daily for compliance for 3 months. If audit sheets have not been completed correctly, the 3 month time frame will be resumed for another 3 months. All residents with GDS of 4 or greater have had Service plan updated to include outdoors only with supervision.

Date of Completion: 9/5/2021

9/5/21 and on-going.

8:11 p.m., indicated she was notified by the QMA the resident had been found outside and the gate was found to be open.

An Emergency Room (ER) report, dated 8/14/21, indicated the resident had a closed fracture of the right wrist. The report indicated to schedule an appointment with an orthopedic surgeon as soon as possible.

A progress note by CNA 1, dated 8/16/21 at 4:20 p.m., indicated a family member was taking the resident to the ER for pain. He indicated the hospital may keep her overnight. The family member indicated he was taking the resident to another nursing facility for rehabilitation.

During an interview on 8/19/21 at 10:14 a.m., the Administrator indicated she was unable to find out who left the gate unlocked. The staff were now checking the gate three times daily. The son had picked his mom up to take to the ER for pain medication. On return from the ER, they only gave an order for Tylenol, which she already had an order for Tylenol. The resident has since been admitted to another facility for rehabilitation.

A copy of an in-service, dated 8/15/21, provided by the Administrator on 8/19/21 at 10:24 a.m., indicated a total of 5 staff members sign for

document to ensure the courtyard gate was locked.

A "Courtyard" form to ensure the gate was locked was signed by all three shifts from 8/15/21 through 8/18/21.

An Unusual Occurrence Report, dated 8/14/21, provided by the Administrator on 8/19/21 at 10:34 a.m., indicated the unwitnessed fall occurred at 8:15 p.m. The report indicated the resident walked out of a back gate, wandered down the road and was found by a person running by. The assessment indicated her blood pressure was 152/82, pulse 101, oxygen saturation 97%.

On 8/19/21 at 10:59 a.m. with the Administrator and Maintenance Director, a WanderGuard watch sensor was activated to check the system. The facility had 2 additional residents with a WanderGuard watch in place. When the door was pressed on to be opened, the sensor alarmed. The porch area was unlocked during the day but had a keyed lock on the steel fence which led out to the parking lot. The Administrator indicated where the resident was found and stated she most likely went through the parking lot and walked on the grass and over a gravel driveway of a private residence. The resident then

walked closer to the condominium complex and fell. The runner was on the road and able to see the resident fall.

Review of a current facility policy, revised 9/2014 titled "RESIDENT BILL OF RIGHTS" which was provided by the Administrator on 8/19/21 at 12:55 p.m., indicated the following:

"...b. Residents have the right to a dignified existence, self-determination and communication...."

This State tag relates to Complaint IN00360399.

Based on interview and record review, the facility failed to ensure a confused resident received the supervision to prevent elopement from the facility for 1 of 3 residents reviewed for risk of elopement. This failure resulted in the resident being without supervision, having a fall with injury and being sent to the emergency room with a fractured wrist. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 8/19/21 at 9:12 a.m. Diagnoses included, but were not limited to, chronic anemia, diabetes mellitus, dementia, and depression.

A fall risk assessment, dated 7/7/21, indicated the resident was at moderate risk for falls.

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A service agreement, dated 7/8/21, indicated the resident enjoyed sitting outside unattended in the courtyard. The resident also needed reminders for exiting in the event of an evacuation and wore a personal watch.

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A progress note, dated 8/14/21, indicated the resident was sitting on the back porch for 2 hours when someone knocked on the door and said a lady was on the ground. Two CNAs checked and realized it was the resident who was on the porch. Her wrist looked out of place. Her blood pressure was 151/82, pulse 101 and oxygen saturation was 97%. A CNA checked the back gate and found it unlocked and it was confirmed the resident had walked out of the unlocked gate.

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and said he saw a woman fall. The CNA asked the resident how she got out and the resident indicated she walked out through the gate. Another aide ran back into the facility to notify the QMA and get items to obtain her vital signs. Her wrist was out of place. They walked to the front porch when the paramedics arrived and took her to the hospital. The resident returned to the facility with a brace on her wrist. The gate had been unlocked by someone other than the other aide or QMA because they had not left the building.

An untimed progress note by QMA 2, dated 8/14/21, indicated the resident was sitting on the porch during medication administration. The QMA decided to leave the resident on the porch because the resident did not want to come in for dinner. A man then knocked on the door and said there was a lady outside that had fallen. One aide went out to get vital signs and to make sure she was okay, and the other aide went to see where she had gotten out of the facility. While on the phone with the Administrator, the aide indicated the gate was unlocked. She attempted to notify the family and then called Emergency Medical Services (EMS). EMS arrived and assessed the resident and transferred her to the hospital

around 8:20 p.m. The family returned her call and then showed up at the facility. Resident B returned to the facility around 10:00 p.m. with a broken wrist and a brace on her right wrist.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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