STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00436483, IN000436526 and IN00435617. Complaint IN00436483 - No deficiencies related to the allegations are cited. Complaint IN00436526 - Federal/State deficiency related to the allegations are cited at F689. Complaint IN00435617 - No deficiencies related to the allegations are cited. Survey dates: June 13 & 14, 2024 Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 0 Medicaid:62 Other: 5 Total: 67 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 6/21/2024	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 5th, 2024, for complaint survey completed June 14, 2024. We respectfully request a desk review for paper compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The facility must ensure that - §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. Based on observation, interview and record review, the facility failed to ensure a resident received adequate supervision and the facility's elopement policy was followed for a resident with a traumatic brain injury with cognitive deficits, who was transferred off facility property, to a physician's office appointment, (Resident B) Finding includes: During an interview on 6/13/24 at 12:45 P.M., a Van Driver indicated he transported Resident B to an office building located next to an acute care hospital in a nearby city on 6/5/24 for a 10:00 AM appointment. During the ride the resident was quiet until he reached the (neighboring city name) and began to talk and point out familiar places and indicated this was his "old stomping grounds". The van driver parked in front of the building and assisted the resident into the building to the specific physician's office and checked him in with Receptionist 1. The van driver told the receptionist he would be back, he had to park the van. When the van driver returned to the physician's office waiting room, the resident was already being seen in the doctor office. The van driver indicated he never went into the exam rooms with the residents due to privacy. The van driver indicated he waited in the lobby,of the suite area, for over an hour for the resident to reappear from the exam room. Finally, he asked Receptionist i2 f the resident was close to being	F 0689	It is the practice of this facility that we ensure each resident receives adequate supervision and assistive devices to prevent accidents. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Upon return to the facility, resident B was placed on visual checks. A wander guard bracelet was placed on his ankle and the elopement assessment was updated. Resident B's information and picture was placed in the elopement book and the care plan was updated to include history of elopement with interventions put in place. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents who are identified as being at risk for elopement per policy have the potential to be affected by the deficient practice(s). A chart review was completed to identify all residents that are at moderate to high risk for elopement. The elopement	07/05/2024

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	done with his exam. Receptionist 2 indicated the resident had left through another door about an hour ago. The van driver asked wich way he had gone and asked them to call security. The physician's office contacted security and they assisted the van driver to search for the resident. Resident B was not located, the office security looked at their cameras and was able to determine how Resident B had exited the building. The van driver then called the facility to report what had happened and the police were contacted. The van driver indicated it was his first time he had taken Resident B anywhere and he had never met him prior to the transport. On 6/13/24 at 2:13 P.M., a review of the clinical record for Resident B was conducted. Resident B was admitted to the facility on 2/27/24. Diagnoses included, but were not limited to: cocaine dependence-remission, stimulant dependence, cannabis dependence, history of pedestrian/collision traffic accident with traumatic subdural hemorrhage. The resident's profile information on admission indicated the resident had no legal Power of Attorney (POA),was his own "responsible party" and had one emergency contact, a sister. A Social Service Note, dated 3/1/24 at 12:17 P.M., indicated the resident was admitted to the facility after being struck by a vehicle, with an admitting diagnosis of traumatic subdural hemorrhage. Resident B had a cocaine and nicotine dependence and severe cognitive deficits. He required cueing and reminders for daily care. The resident had previously been homeless and was to remain in the facility, for long term placement. A Care Plan, dated 3/1/24, indicated the resident		book was reviewed to ensure the information and picture of those residents identified were present in the book. The care plans of identified residents were audited for elopement risk and interventions. A communication form has been developed to be filled out by nursing that communicates information regarding the resident to transport drivers, which includes whether the resident can be left unattended. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policy “Elopement” will be reviewed by the IDT. An in-service will be held with all staff on the policy, including the procedure for a missing resident. A performance improvement tool has been developed to audit that residents who are moderate to high risk for elopement have information included in the elopement book, care plans and interventions for elopement risk are present and communication has been provided to the driver if resident has been escorted to an appointment. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) residents at random to ensure elopement information is	

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	had an alteration in neurological status related to a traumatic brain injury. The interventions included, but were not limited to: cueing and reorientation as needed. An Elopement/Wander Risk Evaluation, dated 3/12/24, indicated the resident was forgetful, had no history of wandering and was a low risk for elopement. A Nursing Progress Note, dated 6/5/24 at 12:30 P.M., indicated the facility had been notified of the resident exiting a physician's office out of the view of the van driver. The note indicated the van driver had alerted the hospital's security and the office building was searched. Resident B was unable to be located. Facility staff were dispatched to assist the van driver with the search for Resident B. A Nursing Progress Noted, dated 6/5/24 at 1:27 P.M., indicated the department was local police department was called and an officer met with the interim Director of Nursing (DON) at the doctor's office. The officer was made aware Resident B was unable to be located. The Police officer spoke with the hospital's security and viewed the cameras to see where the resident had gone. The officer indicated he would talk to his superior to see if they could file a missing person report. At 2:55 P.M., the hospital security officer stated Resident B was seen on the office camera leaving the office at approximately 10:55 A.M. Staff from the facility searched the surrounding areas, including places where the resident had frequented before his admission. Local Emergency Rooms and police stations were contacted and advised of the situation. As of 6/5/2024 at 1:27 P.M., when the note was documented, the resident had not been located.		current and available. This performance improvement tool will be completed by Social Service/ Designee weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* July 5th, 2024	

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	A Nursing Progress Note dated 6/6/24 10:31 P.M., indicated staff had searched the surrounding areas from 9:30 A.M. to 1:30 P.M. Staff resumed their search later in the evening. due to a staff member had reported seeing Resident B in a nearby city in the afternoon. Resident B was not located. The local police department was provided with resident information and the resident's sister was updated. A Nursing Progress Note, dated 6/7/24 at 5:41 P.M., indicated staff had resumed their search throughout the day in the surrounding areas. There were no sightings of Resident B. The resident's sister and the police were updated. A Nursing Progress Note, dated 6/8/24 at 3:15 P.M., indicated the police had called the facility indicating the resident had been found and the sister was aware. An Indiana Department of Health (IDOH) Incident Report dated 6/5/24 at 02:21 P.M. indicated "...Resident transported to ortho appt [appointment] per facility bus driver. The driver is familiar with the facility as he had transported other residents to this location. Driver escorted resident into the building and checked in at the office reception desk, telling the staff he was going to move the facility bus to a parking area. After bus moved, driver immediately returned to the waiting area. Resident was in the exam room being seen. After a period of approximately an hour, driver approached the desk to inquire about the resident, speaking to a different receptionist as the original one was not available. Receptionist stated the resident had already left. The driver had been in the waiting area the entire time after moving the bus. Resident had not exited from the			

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	usual door driver picks residents up at, but exited in his wheelchair from a different door that was not visible from where the driver was seated. Driver requested for receptionist to contact security. Driver searched all floors of medical facility, but unable to locate resident. Driver notified facility that resident was unable to be located. The police (case number INC-2-24-000640) were notified. They observed resident on the camera footage leaving the facility. Family and physician notified. Information received from resident sister regarding places resident frequented as he had previously lived in this area. Facility staff members sent to area to assist with search for resident on date of occurrence and again this date. Resident currently unable to be located...." A Nursing Progress Note, dated 6/11/24 at 2:06 P.M., indicated a Wanderguard (a device to track residents within set borders) had been placed on the resident's right ankle. An Elopement Assessment, completed on 6/13/24, indicated the resident was at moderate risk for an elopement. A Care Plan, initiated on 6/13/24, indicated the resident had exhibited behaviors, such as leaving the facility without notice and talking about living in the woods. The interventions included: Wanderguard placement to remind resident not to leave building alone and IDT (Interdisciplinary Team) to review behavior management program quarterly and as needed. During an observation on 6/13/24 at 3:50 P.M., the resident was locatedout in the courtyard by himself. He was alert to self and place but not oriented to the month or to the name of the			

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	current president, but said it really did not matter to him. During an interview with Resident B, on 6/13/2024 at 3:50 P.M., he indicated he had left the doctor's office because he was done and decided to check out some familiar places and friends in the area. He stayed with his friends and ate with them one day, but traveled to a nearby city by walking behind his wheelchair or propelling himself while sitting in it. Resident B indicated he wanted to check on some things. He had lived in the woods nearby and wanted to see if his things were still there. Resident B stayed in his former shelter and ate the canned goods he had stored there. He had built the shelter out of tarps and had lived there several months before he was hit by a truck in a parking lot. Resident B indicated he just wanted to be free and live by himself in his home in the woods. The police had stopped him 3 times, after he left the physician's office and asked where he belonged and if he needed anything. He told them he did not need anything. At one point, the police told him the facility was looking for him, Resident B told them he did not live there anymore. He wanted to live in his shelter, try to get a job and get his food card pin number and just be free. Resdient B indicated the facility had been nice to him and helped him recuperate from the accident, but he just really wanted to go back to his shelter. He was upset his sister had told the facility where to look for him. Resident B willingly came back with a lady who worked at the facility. Resident B stated again he just wanted to be free to live back in his home-made shelter. On 6/14/24 at 10:10 A.M., the Director of Nursing (DON) provided the address of the physician's office and the address where she had picked Resident B up at, which indicated the resident had traveled 4.5 miles. She indicated the police would not issue a Missing Person alert. She also			

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	indicated there was no documentation, after the resident was returned to the facility from his elopement, that the resident was supervised and checked on at least every 15-30 minutes to ensure of his whereabouts. On 6/13/24 at 3:05 P.M., the Administrator provide a policy titled, "Elopement", dated June 2023 and indicated the policy was one currently used by the facility. The policy indicated "...It is the policy of this facility to provide a safe and secure environment for our residents and to be proactive in preventing residents and to be proactive in preventing resident elopement...Elopement is defined as a resident leaving the premises of the facility without the knowledge and supervision of facility staff...Any resident with a successful elopement will be reassessed and additional interventions will be identified and included with the Plan of Care...." This citation relates to Complaint IN00436526. 3.1-45(a)(2)			