STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 00 B. WING	12/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00248096. Complaint IN00248096 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: December 11 and 12, 2017 Facility number: 000463 Provider number: 155444 AIM number: 100290910 Census bed type: SNF/NF: 19 Total: 19 Census payor type: Medicare: 2 Medicaid: 15 Other: 2 Total: 19 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on December 15, 2017.	F 0000	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the health and safety code section 1280 and 42 CFR 483.	

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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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. 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 who was at risk for elopement received the supervision to prevent elopement from the facility for 1 of 3 residents reviewed for accidents (Resident C). Findings include: Review of the clinical record on 12/11/2017 at 12:32 p.m., indicated Resident C was admitted to the facility on 1/10/2014. Diagnoses included, but were not limited to, acute and chronic respiratory failure, obstructive sleep apnea, dementia with behavioral disturbances, chronic kidney disease stage 3, hypertension, and neuromuscular dysfunctional bladder. The Minimum Data Set (MDS) 5-day dated 11/25/2017, indicated Resident C was moderately cognitively impaired. Resident C was not able to ambulate independently, but could self propel in a wheelchair.	F 0689	**Immediate corrective action(s) for those Residents affected by the deficient practice;** The affected outer door maglock was repaired on 11/29/17 by Maintenance Director. Education provided to therapy staff by ED/Designee on 12/1/17 regarding automatic door and outpatient entrance locking procedure. Inner door alarm was serviced by Automatic Door Controls on 12/7/17 to ensure proper functioning of system. **Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;** Resident's with an elopement assessment indicating they would be "at risk" have the potential to be affected by this alleged deficient practice. Center "At Risk" Residents for elopement status werereviewed by DON/Designee on 12/12/17 & care plans revised as needed.	12/19/2017

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	Review of the facility incident report and the state reportable, indicated Resident C was found outside of the facility by a "facility driver" at 4:10 p.m. The resident had last been seen by facility staff at approximately 3:45 p.m. following an activity. The resident had been outside the facility without supervision for approximately 25 minutes. Review of a progress note, dated 11/20/2017, indicated the resident attempted to exit the facility and fell out of his wheelchair while reaching for the door. The note indicated the resident stated he was going to the ball game. The note also indicated the resident was slightly more confused since his return to the facility from a recent hospitalization. Review of an Elopement Risk Assessment dated 8/16/2017, indicated the resident was a high risk for elopement. Review of an Elopement Risk Assessment dated 11/1/2017, indicated the resident was a high risk for elopement. Review of a care plan, dated 11/29/2017, indicated Resident C was at risk for elopement. Interventions included, but were not limited to, Monitor whereabouts regularly; Recognize any unsafe conditions or escalating patterns. Provide re-direction and diversion as needed (added 12/5/2017). Review of a current care plan dated 12/5/2017 indicated the following;'"Focus		Elopement Book was reviewed and updated per policy and procedure by ED/Designee on 12/12/17. **Facility measures and systemic changes to ensure the deficient practice does not recur;** Automatic Door and Outpatient Entrance Locking Procedure Education provided to therapy staff by ED/Designee on 12/1/17. This sentence is a repeat from above (Immediate action), which may be necessary, but wanted to point out. Elopement and Missing Resident Policy education provided to Social Services Director and Nursing staff by DON/Designee beginning on 12/14/17 and completed by 12/17/17. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process;*** Social Services Director or designee will audit Elopement Risk Assessments on New/Re Admissions & Change Of Conditions weekly X 8 weeks, then every other week X8 weeks, then monthly X2 months to ensure proper identification and interventions of residents who are at risk for elopement. Audit findings will be presented to the QAA Committee monthly x 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process. Compliance will be determined based on results of audits.	

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	Potential Risk of Elopement". Interventions included but were limited to, "Additional plan to prevent elopement, attempts, reoccurence [sic]: Offer resident activities in the private dinning room next to the nurse station. Resident enjoys Farming shows. Monitor whereabouts regularly; Recognize any unsafe conditions or escalating patterns. Provide re-direction and Diversion as needed." During an interview, on 12/11/2017 at 3 :29 p.m., CNA 1 indicated she was in the facility at the time Resident C eloped. CNA 1 indicated the resident often wandered throughout the facility in his wheelchair. The CNA indicated that at approximately 4:00 p.m. she had gone on a break outside and heard someone yelling. She indicated she looked around but did not see anyone. The CNA stated a facility driver had entered the facility property from the opposite direction of her location and spotted the resident. The driver called the facility and informed them there was a resident outside. During an interview on 12/11/2017 at 1:25 p.m., the Director of Nursing and the Administrator indicated Resident B was found outside of the facility by a driver from a sister facility. The Director of Nursing indicated the resident had entered the therapy room through an unlocked door and then exited the facility through the outside door. The outside door did not alarm due to the magnets not aligning. The Director of Nursing indicated the facility immediately had			

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	the alarm repaired. She indicated Resident B had last been seen at approximately 3:45 p.m. and was not seen again until found outside of the facility at approximately 4:10 p.m. The resident had fallen from his wheelchair and sustained a skin tear on in his left elbow measuring 2 cm x 2 cm. No other injuries were noted. The Administrator indicated the facility did not use wandergards. During an observation on 12/11/2017 at 2:30 p.m., of the nursing station no elopement binder was found. CNA 1 indicated the facility used to have one but she had not seen the book "in a long time." During an interview on 12/11/2017 at 3:29 p.m.., CNA 2 indicated he did not know how identify residents at risk for elopement. CNA 2 indicated he watched all the residents because everyone was at risk for elopement. During an interview on 12/11/2017 at 3:37 p.m., the Corporate Consultant indicated the elopement binder had been located in the Social Services Office. The binder lacked any resident information but did contain an inservice for the elopement policy dated 11/29/2017. Review of an undated facility policy, titled "Elopement and Missing Resident," provided by the Director of Nursing on 12/311/2017 at 3:00 p.m., indicated the following: "... Definition An elopement occurs when a			

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	resident leaves the premises or a safe area without authorization or staff notification and /or any necessary supervision to do so. Purpose To assess, monitor, and manage resident safety specific to wandering and elopement. Assessment Guidelines May include (but not limited to): Initial nursing assessment, elopement risk assessment, changes in cognition, and IDT Walking Rounds Reviews. ... Procedural Guidelines ... 6. Complete a Wandering Resident Identification form, which includes a close up photo of the resident. These forms should be maintained in a binder and kept accessible to staff in the location where greatest elopement potential exists, typically the main entry door This Federal tag relates to Complaint IN00248096. 3.1-45(a)(2)			