STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00406982. Complaint IN00406982 - Federal/state deficiencies related to the allegations are cited at F689. Survey dates: April 26 and 27, 2023 Facility number: 000562 Provider number: 155718 AIM number: 100267150 Census Bed Type: SNF/NF: 69 SNF: 4 Total: 73 Census Payor Type: Medicare: 14 Medicaid: 42 Other: 17 Total: 73 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 3, 2023.	F 0000	This Plan of Correction constitutes the written allegation of compliance for deficiencies cited 4/28/2023. The submission of this Plan of Correction is not an admission that a deficiency exists or that it was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. **Please note on the 2567 it is noted the times of resident was out of building was from 6:45pm to 7:20pm. The information that was given and per facility video review was the resident was out of building from 6:45pm to 7:02 pm**	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberley Carlson	HFA	05/12/2023

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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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide adequate supervision to prevent elopement for 1 of 3 residents reviewed for elopement (Resident B). Findings include: Review of a facility self reportable, dated 4/21/2023, indicated on 4/20/2023 at 7:02 p.m., Resident B was found by a visitor in the parking lot of the facility attempting to get into a parked car. The resident exited the facility at approximately 6:45 p.m. and was returned to the facility at 7:20 p.m. The resident was outside the facility, unsupervised, for approximately 35 minutes. The clinical record for Resident B was reviewed on 4/26/2023 at 9:40 a.m. Diagnoses included, depression, hallucinations, severe vascular dementia, and anxiety. The admission Minimum Data Set (MDS) assessment, dated 4/18/2023, indicated the resident displayed behaviors to include wandering and delusions. A statement written by RN 7, dated 4/20/2023, indicated at approximately 7:10 Resident B attempted to exit the facility through the front door. The wander guard alarm sounded and the resident was noted sitting in a wheelchair and pushing buttons on the front door code box. The resident was redirected back to the unit and the fire doors were closed. The resident was self propelling himself up and down the hallways on the unit. At approximately 7:20 p.m., a CNA from	F 0689	**F689 (SS D) What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** This deficient practice, as identified in 2567, was immediately addressed when brought to the attention of the DON and ADON and Administrator. Staff were re-educated regarding the Importance of alarms in the facility in the facility. Resident was placed on routine checks and one on one supervision when out of bed. Resident had a bed alarm to notified staff when he attempted to get out of bed without assistance, resident was unsafe to transfer without assistance of staff. A maintenance staff member was called in to check on the integrity of the door that resident exited from. Resident was evaluated for a facility that had a locked dementia unit and was accepted. Transfer was completed on 4/21/2023 at approximately 1:00 PM. Resident was monitored until transfer. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:**	05/19/2023

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	another unit stated a visitor said there had been a gentleman in a wheelchair in the front parking lot, and they appeared to be confused. The CNA was able to redirect the resident back into the facility through the front door and returned the resident to the appropriate unit. During an interview on 4/26/2023 at 12:07 p.m., RN 7 confirmed her written statement. During an interview and observation on 4/26/2023 at 9:43 a.m., the Administrator indicated Resident B exited the facility through the therapy exit door. The exit door at the end of the 300 hall led to a hallway with the therapy exit door, which then led to the outside (west parking lot). The therapy exit door had a 15 second delayed alarm, but no wander guard alarm installed. The resident was familiar with the facility, as their late spouse had previously resided at the facility. During an interview on 4/26/2023 at 10:53 a.m., CNA 1 indicated after the resident was returned to the facility, he stated he as looking for his wife. During an interview on 4/26/2023 at 11:04 a.m., NA 2 indicated they had been outside with another resident. A visitor approached NA 2 and stated there was a confused man in the parking lot. NA 2 found Resident B in a wheelchair next to a vehicle and attempting to remove his alarm clip. The resident was easily redirected back into the facility. During an interview on 4/26/2023 at 11:18 a.m., the interim Maintenance Director indicated, to his knowledge, the therapy gym door had never had a wander guard alarm installed prior to the incident. During an interview on 4/26/2023 at 11:24 a.m.,		Residents are evaluated upon admission and quarterly or if change in condition for non-purposeful wandering or sign or symptoms of wanting to leave the building. Residents who exhibit signs of potential exit seeking will have a wander guard/code alert placed for their safety. Wander guards are audited each shift for patency and placement. Maintenance audits doors with wander guard alarms weekly to ensure in working order. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur:** Code on the non-wander guard alarm/code alert doors has been changed and will remain different than codes for the code alert/wander guard doors. The code will not be visible at these non-code alert doors. The door will activate the alarm if residents push but these are fire exit doors only. **How will the corrective action be monitored to ensure the deficient practice will not recur:** All exiting doors are monitored weekly by maintenance staff and security codes are changed monthly. MDS will schedule and monitor for completion of the elopement risk assessment. Elopement drill will be performed	

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	agency QMA 4 indicated the resident had attempted to exit the facility from the front door. QMA 4 heard the alarm. The resident was redirected back to the unit. The staff closed the double fire doors so the resident would not be tempted to exit from the front doors again. The resident was not agitated or upset. She was told the resident was found in the parking lot. She had not heard the door alarm on the 300 hall. QMA 4 asked the resident how he got out of the facility and the resident responded, "I went out the back door." During an interview on 4/27/2023 at 10:49 a.m., LPN 8 indicated she observed the resident attempting to remove the clip alarm while she was getting report. The resident was self propelling himself to different doors. The resident went to the front door and the wander guard alarm went off. The resident was brought back to the unit. LPN 8 was not aware of when he got out of the facility. Review of a current policy dated 5/10/2019, titled "Elopements and Wandering Residents" and provided by the Administrator on 4/26/23 at 10:28 a.m., indicated the following: "Policy: Residents will be assessed for elopement risk on admission and throughout their stay by the interdisciplinary care planning team. The facility is equipped with door locks/alarms to help avoid elopements. "Elopement" occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so...." A copy of the door alarms check log was not provided by the facility. No further information was provided. This Federal tag relates to Complaint IN00406982.		monthly x 3 months then quarterly pending compliance.	

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