STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155153	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHWIN	**20531 DARDEN RD SOUTH BEND, IN 46637**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00393010 and IN00389421. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00393010- Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00389421 - Unsubstantiated due to lack of evidence Survey dates: November 14, 15, 16 and 17, 2022 Facility number: 000073 Provider number: 155153 AIM number: 100288820 Census Bed Type: SNF/NF: 90 SNF: 9 Total: 99 Census Payor Type: Medicare: 12 Medicaid: 67 Other: 20 Total: 99 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 11/23/22.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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

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F 689	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure safety their elopement policy was followed for a resident who was deemed at high risk for elopement and displayed exit seeking behaviors, which resulted in a resident exiting the premesis unattended. (Resident B) The immediate jeopardy began, on 10/24/22 at 7:54 A.M., when Resident B was last observed on the facility's video surveillance system exiting the facility, with the Administrator. The Administrator was observed to return inside the facility, leaving the resident unattended in a facility park area, which allowed the resident to proceed to an unlocked gate and exited the facility park, circling around to the front of the facility and ended up in the facility parking lot, before the resident was assisted back into the facility. The Administrator was notified of the immediate jeopardy on 11/15/22 at 1:04 P.M. Finding includes: A self-report incident, dated 10/24/22, indicated "...Wander guard was placed on [name of Resident B] on 10/20/22. [Name of resident] wanted to go out the front door around 7:57 am. She was redirected from the front door and offered the park area to go outside. She was	F 689	Past noncompliance: no plan of correction required.	

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shown the park area. She asked if she could hang out in the park by herself. Went out to check on her about 5 minutes later. [Name of resident] left the walker in the park and exited the east gate door. There were no security chains in place. [Name of resident] was found walking down the front parking lot by the ADON [Assistant Director of Nursing]. She was brought back into the facility asked where she was going. She stated, "I'm going home." This writer asked how she was getting there; she stated, "by taxi". This writer asked how was she going to pay for the tax, she stated, "I was going to go to the bank and get some money....."

During an interview, on 11/14/22 at 10:37 A.M., the Administrator indicated Resident B was wandering near the front entrance and displaying exit seeking behaviors. The Administrator indicated she had re-directed the resident to a park area, outside of the facility. She left the resident unattended and explained to the resident she would be back, to check on her, in 5 minutes. When the Administrator returned to the park, the resident was no longer in the area, where she had left her. The Administrator indicated she spotted the resident's walker in some tall grass and the security chain, which locked the exit gate, was located on the ground. The Administrator indicated she followed the sidewalk, around building, towards the front of the facility. The resident was observed, by the Administrator, walking across the parking lot. The Administrator observed the ADON, who was walking toward the facility entrance and motioned her to retrieve the resident. The ADON brought the resident back into the building.

A hand-written note, dated 10/24/22, indicated the

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Administrator had spoken to Maintenance Staff Member 2 and the Maintenance Director/Chief Financial Officer and they indicated a new groundskeeper had left the gate unlocked. (This had been verified by a video surveillance system by the CFO) The note indicated "...wasn't locked after yard work around fences, completed on 10/21/221, chain link fence was located on the ground ...."

On 11/14/22 at 10:50 A.M., a review of the clinical record for Resident B was conducted. The record indicated the resident was admitted on 10/11/22. The resident's diagnoses included, but were not limited to: diabetic ketoacidosis, acute encephalopathy, depression and anxiety.

A Hospital Transfer Form, dated 10/11/22, indicated the resident was alert and confused.

A Nurse Practitioner Progress Note, dated 10/13/22, indicated the resident was confused, disoriented and trying to get out of her room.

An Elopement Risk Assessment, dated 10/13/22, indicated the resident had scored a 3. The Assessment indicated " ...Score of 4 or More indicates Risk and Requires Interventions/Care Plan...."

A Minimum Data Set (MDS) Assessment, dated 10/18/22 indicated the resident had wandering behavior 1-3 days a week and had no wander/elopement alarm.

A Nursing Progress Note, dated 10/18/22, indicated the resident was extremely non-compliant with isolation precautions, had required re-direction, reassurance and education

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multiple times.

A Nursing Progress Note, dated 10/20/22 at 2:03 P.M., indicated Resident B remained on Covid isolation precautions and remained non-compliant with following those precaution by "...continuing to exit intermittently out of room, and opening door, resident continues to require frequent redirection and reminders that precautions need to be followed...Resting in room at this time with call light within reach, resident does not utilize call light and requires reminders to utilize call light to summon staff to room...."

A Nursing Progress Note, dated 10/20/22 at 5:30 P.M., indicated a wanderguard was placed on the resident's right wrist.

A Care Plan, dated 10/21/22, indicated resident was at risk for an elopement related to confusion and wandering the facility. The interventions included but were not limited to: bracelet alarm in place, with placement checks every shift, alarm function checks weekly, and a photo of resident placed at front desk. Distract resident from eloping or wandering by offering pleasant diversions, structured activities, food, conversation, TV, or book. And provide identification band on resident, walker or wheelchair.

An Elopement Risk Assessment, dated 10/22/22, indicated the resident was at high risk for an elopement. The assessment indicated Resident B was frequently stating she wanted to go home and was having purposeful exit seeking behaviors.

On 11/14/22 at 12:01 P.M., an observation of the

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facility's video surveillance system was conducted with the Maintenance Director/CFO. The video indicated the resident was observed on 10/24/22 at 7:52 A.M., as she entered the front lobby area. She was using a walker and had a jacket on with a hood. The resident attempted to go out the front entrance/exit door, after leaving her walker behind. A staff member was observed to re-direct the resident while another staff member was observe to punch in a code to disarm the wanderguard alarm. The CFO indicated when the resident walked near the door the wanderguard would alarm. Then staff blocked the door way with a retractable ribbon. Resident was observed on the camera to go up to the ribbon several times, then at 7:54 A.M. resident goes toward a hallway and out of camera observation. At 7:54 A.M. the resident and the Administrator were observed to exit out another door to a park area, on the facility grounds. The Administrator was observed showing the resident a button to press when she was ready to return inside the building. Administrator then goes into the facility and leaves the resident unattended, in the park area The resident was observed to walk away from the door and down a ramp with her walker at 7:55 AM. At 7:56 AM the resident goes out camera as she turns toward the side of the facility. At 8:01 AM the resident is picked up by the video camera, out in the parking lot, walking towards the handicap parking areas and out of camera visualization. At 8:05 AM the camera located at the front lobby area shows the resident walking into the facility with a staff member. The CFO indicated the camera which could possibly visualize where and what the resident did in the parking lot had a blank screen, a possible malfunction.

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On 11/14/22 at 12:34 P.M., the CFO and surveyor traced the resident's steps. The resident walked down a ramp that had a fence located on both sides of the ramp. The first turn in walkway, the resident was observed to take, went directly to aluminum/steel gate with a chain-link and padlock. The CFO indicated this was the gate that was left unlocked. The gate was swung opened and quickly shut itself closed. The gate had a push button and lever that had to be opened, at the same time, to allow the gate to re-open. The walkway took us to parking lot where the resident had exited the walkway out into the parking lot. This was approximately 1000 feet from the gate to the parking lot. Once the resident was in the parking lot, she was between 100-200 feet from the front door, with a busy street, to the south of the parking lot.\

During an interview, on 11/14/22 at 3:07 A.M., Maintenance Staff Member 2 indicated he was instructed to check the fences to make sure they were secure, the day of the resident's elopement. He indicated he found the east gate closed, however the chain-link and lock were located on the ground, next to the gate.

On 11/14/22 at 4:23 P.M., the Administrator indicated the resident was not placed on 1:1 observation and had not made any other attempts to exit the facility.

On 11/14/22 at 10:20 A.M., the Administrator provided a policy titled, "Elopement and Wandering Residents", undated and indicated it was the policy currently used by the facility. The policy indicated "...Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate

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supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Policy Explanation and Compliance Guidelines: 1. "Wandering" is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless. 2. Elopement is defined as "when a patient or resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired wanders away, runs away, escapes, or otherwise leaves a care-giving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge."...6. Monitoring and Managing Residents at Risk for Elopement ...e. Adequate supervision will be provided to help prevent accidents or elopements...."

The immediate jeopardy was removed and corrected, on 10/25/22, when the facility maintenance/grounds keepers were in-serviced, regarding the locking of an exit gate, and the implementation of audits confirming gates were being observed/checked daily for compliance and all staff were informed of the resident's elopement to ensure her safety until she discharged from the facility on 11/1/22.

This Federal tag relates to complaint IN00393010.

3.1-45(a)(2)