| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155506 | A. BUILDING 00<br>B. WING | 10/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SANCTUARY AT HOLY CROSS | 17475 DUGDALE DR<br>SOUTH BEND, IN 46635 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00392425.<br><br>Complaint IN00392425- Substantiated. Federal/state deficiencies related to the allegations are cited at F689 .<br><br>Survey dates: October 25 & 26, 2022<br><br>Facility number: 001201<br>Provider number: 155506<br>AIM number: 100380860<br><br>Census Bed Type:<br>SNF/NF: 42<br>SNF: 27<br>Total: 69<br><br>Census Payor Type:<br>Medicare: 24<br>Medicaid: 42<br>Other: 3<br>Total: 69<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed 10/31/22. | F 0000 | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§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

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.<br>Based on observation, interview and record review, the facility failed to provide adequate supervision for a resident with severe cognitive deficits and behaviors of wandering and wore a wander guard (a device with an alert sensor to monitor and/or prevent residents from exiting the facility), resulting in an elopement for 1 of 3 residents who wore a wander guard. (Resident B)<br><br>Finding includes:<br><br>Incident #539 indicated, on 10/24/22 at approximately 11:51 A.M., Resident B left the building, via the rehabilitation lobby exit and was brought back into the building, by a staff member, at 11:55 A.M. The resident was approximately 25 feet from the building. The family and physician were notified. The resident's wander guard was replaced, and the resident was placed on 15 minutes observation checks. The initial investigation indicated a door from the resident's unit into the rehabilitation unit had a maglock with a key punch. The door would remain unlocked for 45 seconds, this time was changed to 10 seconds. All wander guard doors were checked, including the rehabilitation door, for there function ability and all were functioning properly.<br><br>During an interview, on 10/25/22 at 10:25 A.M., the Administrator indicated there were several reasons the resident was able to exit the facility. One, was the receptionist just happened to leave her post, at the doorway, to go into the restroom. A therapist exited from the Long-Term Area into the Rehabilitation area and the door was unlocked for 45 seconds, which allowed the resident | F 0689 | **This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by state and federal law.**<br>Sanctuary at Holy Cross respectfully requests this Plan of Correction and supporting documentation be considered for desktop review/paper compliance.<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>A head count (See attachments A & A1) was completed for the entire facility to ensure that there were no other resident's unaccounted for. The resident was immediately assessed by the nurse to ensure that there were no signs or symptoms of injury. The resident was immediately placed on 15 min | 11/25/2022 |

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| | enough time to cross over into the rehabilitation hallway/lobby. Then the wander guard did not alarm nor lock the exit door, which allowed the resident to exit the building. The Administrator explained the wander guard's alarms are transmitted to the nursing staff via a pager and none of the staff received an alarm, when the resident went through the exit doorways.<br><br>The Administrator provided a QAPI (Quality Assurance And Performance Improvement) concern which stated " ...Resident wearing wander guard exited building without alarming ...."<br><br>A form titled " ...Root Cause Analysis Summary Report - [name of facility]; Elopement, dated 10/24/22 indicated " ...B. Timeline 10/24/22<br>At 11:48:52 therapist exited internal hallway door<br>At 11:49:26 resident exited through that same internal hallway door<br>At 11:48:05 receptionist at entrance went to use the restroom<br>At 11:51:01 resident exited through lobby doors into parking lot<br>At 11:55:53 staff observed resident in parking lot approximately 25 feet from entrance and escorted her back into the facility.<br>It was noted that wander guard did not alarm when she exited the building, the door did not lock as would be anticipated, and it did not alarm when resident was brought back into the building ...."<br><br>A typed statement from the Social Service Assistant 3, dated 10/24/22, indicated " ...It was reported to me that [name of resident] had been able to exit the facility through the front door. I completed an inspection of [name of resident] wander guard at this time and found it to be in | | checks (See attachments B & B1). The Wander guard bracelet was checked for function with the machine and validated it was functioning properly. Even though bracelet was functioning facility replaced with new bracelet.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;<br><br>These residents each had wander guards checked for functioning and all are functioning properly. Facility replaced all resident wander guard bracelets with new ones despite old ones working. ISDH surveyor in the building was shown proof that the wander guards were replaced and functioning.<br><br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>Internal doorway lock initiation time has been changed from 45 seconds to 10 seconds (See attachment C). Compass wander guard company used by facility has come out and found no faults | |

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| | working order. [Name of resident] was then taken back to the front door to check if her wander guard was not activating the front door to lock. At this time the front door did lock as appropriate when [name of resident] got close wearing the wander guard ...[Name of resident] verbalized to me during this conversation that she went through the door because "a red-headed man said it would be ok", as well as "I was hungry, and thought my lunch was out there ...As a precautionary measure, [name of resident] wander guard was replaced at this time to reduce risk. I performed a check with this wander guard as well, and it was found to be in working order ...."<br><br>A facility camera observation, on 10/25/22 at 11:00 A.M., with the Administrator, the Assistant Director of Nursing (ADON) and the Payroll/Staffing Coordinator/camera operator confirmed the timeline above. The resident was observed propelling herself, in a wheelchair and was wearing a sleeveless top, long pants, and tennis shoes. The resident was observed to exit the locked hallway door, between the units and then proceeded to propel herself towards the exit doors. After she exited the building, she crossed the overhang driveway and proceeded to the parking lot, where she was observed at the end of the blue handicap lines. She then turned her wheelchair around and headed toward the overhang but turned towards another parking lot and was out of sight. Then two staff persons were observed to exit the facility and assisted the resident back into the building.<br><br>A review of the facility's Elopement Book indicated the book had pictures and face sheets of 3 residents who wore a wander guard, which included Resident B, Resident D and Resident F. The ADON indicated these residents are the only | | with doorways (See attachment C1). In addition, wander guard triggered mag lock has been placed on internal doorway (See attachment C2). Also, loud alarm will trigger on east internal door when opened without a code being entered. All staff will be educated by 11/25/22 on Increased Wandering Behavior and elopement policy and revision (See attachment D).<br><br>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; an<br><br>Maintenance will complete audits 5x a week for 3 week(s) then resume weekly audits for all doors alarmed with wander guards to ensure functioning (See attachment E).<br><br>Social services will complete audits 5x a week for 3 week(s) then resume weekly audits for all residents with wander guards to ensure functioning (See attachment F). These will be reviewed in Monthly QAPI.<br><br>5. By what date the systemic changes for each deficiency will be completed. After submitting an | |

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| | residents who were at high risk for elopement.<br><br>On 10/25/22 at 12:05 P.M., a review of the clinical record for Resident B was conducted. The resident's diagnoses included, but were not limited to: dementia with behavioral disturbance, anxiety disorder, delusional disorder and difficulty walking.<br><br>A Care Plan, dated 12/8/20 to present, indicated the resident " ...often is wandering the facility, looking for her husband, or looking for the doctor that her sister is married to [name of resident] husband passed several years ago) or asking if she is working today [name of resident] is a retired LPN). Wander Guard is placed on [name of resident] left ankle ...." The interventions included but were not limited to: staff to redirect resident when she's looking for her husband, assist to her room or an activity, staff to daily check the placement of the wander guard and social service staff to check wander guard weekly...."<br><br>A Quarterly Minimum Data (MDS) Assessment, dated 9/13/22 indicated the resident had severe cognition deficits, had behaviors of wandering 1-3 days a week, used a wheelchair and her locomotion, on the unit, was self-sufficient once in her wheelchair.<br><br>A Wandering/Elopement Risk Assessment, dated 9/7/22, indicated the resident did not have wandering behavior or exit seeking behavior and her risk of elopement score was "0".<br><br>A Progress Note, dated 10/8/22, 3:11 A.M., indicated "...resident up in w/c [wheelchair] propelling self up and down hallway, stops and tries to enter other residents rooms if sees staff in room. confused to place, time and disoriented to | | acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.<br><br>Systemic changes will be completed by 11/25/22. | |

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| | normal routine...."<br><br>A Progress Note, dated 10/9/22 at 10:09 P.M., indicated "...Resident rolling up and down hallway, told this nurse that she had work today. This nurse remined resident that she was retired and that she live here...."<br><br>A Progress Note, dated 10/24/22 at 1:57 P.M., indicated " ...Resident is alert in cushioned WC [wheelchair]. Found in East side of building by maintenance personal in the am. Brought back to proper hall. Later a Rehab nurse brought resident back to St Joseph Hall. Nurse stated, "I found her outside in the far parking lot". Wander alarm located on lower extremity. Checked by Long Term Social Services to be working correctly. Resident stated, "The man with red hair let me out". Educated resident on the importance of staying in the facility ...." This Progress Note was documented by RN 4, which was unable for an interview.<br><br>A Progress Note, dated 10/24/22 at 4:56 P.M., indicated IDT (Interdisciplinary Team) met to review measures to maintain a safe environment for Resident B. The Note indicated Resident B exited the building, in a wheelchair, and was outside the building 4-5 minutes before staff were able to bring her back into the facility.<br><br>The October TAR indicated the wander alarm had been checked every shift (3 times a day) by a nurse and was documented by the nurse's initials.<br><br>On 10/25/22 at 12:30 P.M., an observation of the exit and parking lot was conducted with the Maintenance Director and the ADON. The Maintenance Director measured from the last doorway, the resident exited, to the parking lot | | | |

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| | where the resident was observed on the camera, and it measured 109 feet.<br><br>During an interview, on 10/25/22 at 12:49 P.M., LPN 2 indicated she observed the resident, outside, in the parking lot, from the second floor unit, she called St. Marks Unit, on the first floor to alert them of her observation. LPN watched the resident until she observed the nurse approaching the resident.<br><br>On 10/25/22 at 12:56 P.M., the resident was observed in the TV lounge/dining area, facing the TV. She was alert to self only. She had a wander guard on her left ankle. She was sitting in a wheelchair with no foot pedals. She had her gym shoes on and tied. Her hair, nails and clothes were clean. She indicated she was happy. The resident's room was located 3 doorways away from the internal locked doorway, which entered into the rehabilitation units.<br><br>During an interview, on 10/25/22 at 2:58 P.M., the Maintenance Technician indicated he found Resident B just inside the closed East wing doors. (A unit that was closed and no longer was housing residents.) He indicated she was sitting in her wheelchair with a cup of water. He directed her back to her unit approximately 150 feet away. This occurrence happened prior to to exiting the facility.<br><br>During an interview, on 10/27/22 at 11:55 P.M., the Administrator indicated the hallway used by the resident to propel herself to the East closed unit, was commonly used by the residents, as the activity room was off the same hallway. The Administrator indicated the resident was observed, on camera footage, going into the closed unit at 11:30 A.M., then at 11:32 A.M., the | | | |

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| | Maintenance Technician was observed to locate the resident. The Administrator indicated the company who services the wander guards was at the facility yesterday and found no technical difficulties with the wander guard devices were found.<br><br>On 10/26/22 at 11:53 A.M., the ADON provided a policy titled, "Increased Wandering Behavior", dated 10/26/22, and indicated the policy was the one currently used by the facility and staff were being in-serviced on. The policy indicated "...Resident with impaired cognition or dementias may exhibit various behaviors such as restlessness and wandering. The facility will implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident; and/or monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice. Adequate supervision may vary from resident to resident and from time to time for the same resident...If a staff member identifies that a resident has increasing wandering tendencies or is exit-seeking, notify the charge nurse of this observation. Charge nurse or staff will notify social services regarding increasing wandering or exit-seeking tendencies...."<br><br>This Federal tag relates to complaint IN00392425.<br><br>3.1-45(a)(2) | | | |