STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING _____ B. WING _____	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00413173. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00413173 - Federal/State deficiency related to the allegation is cited at F689. Survey dates: July 19, 20 and 21, 2023 Facility number: 002657 Provider number: 155681 AIM number: 200308930 Census Bed Type: SNF/NF: 37 SNF: 44 Total: 81 Census Payor Type: Medicare: 21 Medicaid: 24 Other: 36 Total: 81 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 26, 2023.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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	F 689		

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

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F 689	Continued From page 1 §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 a resident (Resident B) on the secured dementia unit with exit seeking behaviors did not exit the facility without supervision for 1 of 3 residents reviewed for supervision. This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 7/17/23 when a resident exited the 300 Hall door on the dementia unit by pressing on the egress bar which sounded the alarm and opened after 15 seconds. After the resident exited the facility, he turned left and ambulated in a straight line up a small hill then down a hill which led to the apartments adjacent from the facility. The resident was off the facility property. Had the resident ambulated left rather than straight, he could have reached a heavy traffic flow roadway. The resident was found trying to enter and use a key into an unknown person's vehicle located in the parking lot of the apartment building. The Executive Director, Director of Nursing, Area Vice President of Clinical, and the Division Vice President were notified of the Immediate Jeopardy on 7/19/23 at 3:30 p.m. The Immediate Jeopardy was removed on 7/21/23. Findings include: The clinical record for Resident B was reviewed on 7/19/23 at 12:40 p.m. The diagnosis included, but was not limited to, dementia without behavioral disturbance. The admission MDS	F 689	Past noncompliance: no plan of correction required.	

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(Minimum Data Set) assessment, dated 6/8/23, indicated the resident had moderately impaired cognition.

The incident report, dated 7/17/23 at 10:01 a.m., indicated Resident B exited the building causing the door alarm to sound. Staff responded to the alarm and checked the area outside. Staff completed a head count and found that Resident B was not present in the unit. A search was initiated to include the campus and the perimeter of the campus. The resident was found in the parking lot of the apartment building directly adjacent to the campus, with his car keys in hand and attempting to enter a person's vehicle. The owner of the vehicle lived in the apartment complex and was attempting to redirect the resident. Staff were able to redirect the resident and returned him safely to the campus. The time of exit was approximately 10:00 a.m. The resident was located at 10:15 a.m. No injuries were noted.

On 7/19/23 at 1:15 p.m., the Executive Director provided a security video snapshot of the resident outside the facility\, reviewed after the resident had eloped, dated 7/17/23 at 9:58 a.m. The resident was observed to be ambulating up the hill adjacent to the facility with the use of his cane.

The admission elopement risk assessment, completed on 6/2/23, indicated the resident had no exit seeking behaviors.

The care plan, dated 6/7/23, indicated the resident demonstrated exit seeking behaviors and the family declined the wander guard. The interventions included, but were not limited to, monitor for wandering triggers, provide a daily structured routine, encourage regular family

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contact and/or visits with others, offer diversional activities as needed and redirect resident away from doors/exits as needed.

The progress note, dated 6/3/23 at 10:41 a.m., indicated the resident had been exit seeking, he tried to open every door, and needs constant redirection. A wander guard was placed on his right ankle.

The progress note, dated 6/4/23 at 12:53 a.m., indicated the resident had been restless and wanted to find "his other room". He had gone to the doors and pushed on them; however, he did not try to open them.

The IDT (Interdisciplinary) note, dated 6/5/23 at 12:08 p.m., indicated the resident admitted to facility and observed with exit seeking/wandering behaviors. A wander guard was put in place, but the resident was able to remove the wander guard. The staff will attempt to replace the wander guard and review the informed consent and non-compliance with resident representatives.

The progress note, dated 6/5/23 at 8:33 p.m., indicated the resident had been ambulating in the hallway with his cane and had verbalized that he wanted to return home.

The progress note, dated 6/6/23 at 10:51 p.m., indicated at approximately 8:15 p.m., the nurse prevented the resident from exiting the facility. The resident had been pacing, wandering, and pushing on the doors. He was able to be redirected but needed redirection frequently. The nurse was alerted to a door alarm sounding down the hallway. The resident was found pushing the

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exit door in the living room area. As soon as the nurse placed her hand on the resident to redirect him, the door opened, and the resident took two steps out. He was redirected back into the facility and 15-minute checks were initiated.

The progress note, dated 6/11/23 at 8:02 p.m., indicated the resident demonstrated exit seeking behaviors on this shift. The resident was observed by staff setting off the alarms on the hallway. He had self-removed his wander guard and was looking for his keys. When he was not in direct observation, staff checked on him frequently.

The progress note, dated 6/28/23 at 9:27 p.m., indicated the resident had gone to every door and tried to open them. The resident stated "he knows that he has been out of one of these doors before. He needs to get outside to his car and get out of here. He is not staying here". He had a key that he tried to stick in the door to open it. He was difficult to redirect at first but did finally go to his room and settle down.

The progress note, dated 7/17/23 at 10:10 a.m., indicated it was reported by the housekeeper that the back door was alarming, and the staff needed to do a head count. After the head count it was determined Resident B was missing. Staff immediately looked in all the resident rooms, bathrooms, and looked out the windows. During this time three other staff members used their cars to search for the resident. The resident was found at the apartments next door to the facility and was immediately brought back to the facility. The resident was not hurt and appeared to be fine.

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During an interview on 7/19/23 at 12:19 p.m., the Executive Director indicated the resident exited through the doors at the end of the 300 Hall of the dementia unit. He pushed the regress bar, and the door opened after 15 seconds. The door alarms sound right when the bar was pushed. At the time of the incident, they were having a music activity. There was one nurse was at the nurses' desk and the other nurse was at the medication cart.

During an interview on 7/19/23 at 1:36 p.m., Housekeeper 3 indicated he had worked on the dementia unit on 7/17/23. A little before 10:00 a.m., he took his cart down the 300 Hall. He was about 20 to 25 feet from the door when he heard the alarm sounding. There was a TV activity going on at the time and the alarm could not be heard in the common area where the activity was taking place. He was not sure why, but the alarm was usually louder. He never observed the resident. He checked outside and did not see anyone. He reset the alarm, went to the nurses' station to have the nurse do a head count, because the door was open. A head count was completed, and the missing resident was identified (Resident B). He reported the missing resident to the Administrator and he, along with two other staff members, began searching for the resident outside.

During an interview on 7/19/23 at 1:54 p.m., the Director of Plan Operations indicated after the last elopement in March 2022, a new feature was added which he called "the screamer". It was very loud. He checked all the alarms daily, Monday through Friday, but had not yet check the alarms prior to this last incident. The "screamer" did not go off this last time due to a possible power

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surge.

The safety and security company invoice, dated 7/17/23, indicated upon arrival, the facility wanted a door (300 Hall) checked because it did not alarm. The hallway (300 hall) had a space age annunciator. The annunciator was not hooked to the door and the wire was disconnected. The door was wired into a horn strobe that would go off when forced open. A power surge had reset the keypad which caused the strobe not to trigger.

During a telephone interview on 7/21/23 at 11:21 a.m., Representative 15 with the safety and security company indicated they were at the building on 7/17/23 between 2:37 p.m. and 5:46 p.m.

The witness statement, dated 7/17/23 and untimed, for CNA (Certified Nursing Aide) 5 indicated she was not on the unit at the time of the incident.

The witness statement, dated 7/17/23 and untimed, for CNA 6 indicated she was on break with CNA 5 and she was not on the unit at the time of the incident.

The witness statement, dated 7/17/23 and untimed, for CNA 8 indicated she was giving a shower to a resident on the 200 Hall during the time of the elopement. Prior to CNA 8 entering the resident's room on the 200 Hall for a resident's shower, she had observed Resident B heading in the direction of the main living room. She was unsure of the time.

During an interview on 7/20/23 at 1:56 p.m., RN 9

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indicated she had worked the dementia unit on 7/17/23. It had been her first day on her own since she completed orientation. She knew who Resident B was because she had administered his medications. The medication cart was around the corner of the 300 Hall, and she could not see down the 300 Hall. She did not hear an alarm sound. She did hear the resident call lights sounding. There was a lot of background noise because of where the medication cart was located, and an activity was taking place. She was focused on the accuracy of pulling medications and did not see the resident pass by prior to the incident. She had since moved the medication cart to the 300 Hall where she could now see down the hall.

During an interview on 7/20/23 at 2:21 p.m., LPN (Licensed Practical Nurse) 10 indicated she was sitting at the nurses' station charting. She could not hear the alarm sounding since there was a loud activity going on. She did not see the resident go by nor could she see the end of the 300 Hall from where the desk was situated.

During an observation of the facility video footage, on 7/21/23 at 9:48 a.m., the footage indicated on 7/17/23 at 9:55 a.m. Resident B was observed to ambulate slowly, with his cane, down the 300 Hall towards the exit door. The resident was observed to push the egress bar. The door opened 15 seconds later, and the resident exited out of the facility at 9:56 a.m. At 9:57 a.m., the resident was observed from the front parking lot security camera. He ambulated slowly up the hill with his cane towards the apartment complex. Once over the hill, the camera lost view of the resident. At 10:05 a.m., the housekeeper was observed to walk quickly down the 300 Hall

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towards the exit door. He looked out the door window and then turned off the alarm. He then walked quickly up towards the 300 Hall nurse's station and the camera lost view of the housekeeper. Review of the security camera footage from the parking lot entrance, indicated the resident was observed to be back on facility grounds at 10:18 a.m. He was with the facility staff who had been out searching for the resident. After reviewing the timeline of the resident from exit to return, the resident was out of the facility for a total of 22 minutes and unsupervised for 19 of those 22 minutes.

During an interview, on 7/21/23 at 9:53 a.m., the ED indicated staff had texted him, on 7/17/23 at 10:15 a.m., to indicate the resident was found in the apartment complex.

On 7/19/23 at 1:10 p.m., a current copy of the document titled "Elopement Risk Assessment and Prevention" was provided and dated 9/28/16. It included, but was not limited to, "Purpose...The campus strives to promote resident safety and protect the rights and dignity of the residents...Elopements occur when a resident leaves the premises or a safe area with authorization...and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of...heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle...A check will be completed of alarmed doors...to ensure proper functioning...."

The Past noncompliance Immediate Jeopardy began on 7/17/23. The Immediate Jeopardy was removed, and the deficient practice corrected by 7/18/23 after the facility implemented a systemic

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F 689	Continued From page 9 plan that included the following actions: The facility completed staff education on supervision and elopement/missing resident policy (7/18/23), facility wide resident re-assessment completed for elopement risk (7/17/23), care plans reviewed on residents at risk for elopement (7/17/23), elopement drill conducted (7/18/23), and facility managers were educated on how to check door alarms with alarm checks to include the weekends (7/18/23), and the door alarm was fixed and checked (7/17/23). This Federal tag relates to Complaint IN00413173 3.1-45(a)(2)	F 689		