| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155771 | A. BUILDING 00<br>B. WING | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE | 1070 W JEFFERSON ST<br>FRANKLIN, IN 46131 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00440361, IN00440412, and IN00442884.<br><br>Complaint IN00440361 - No deficiencies related to the allegation are cited.<br><br>Complaint IN00440412 - No deficiencies related to the allegation are cited.<br><br>Complaint IN00442884 - Federal/State deficiencies related to the allegations are cited at F689.<br><br>Survey dates: September 25 and 26, 2024<br><br>Facility number: 001127<br>Provider number: 155771<br>AIM number: 200247220<br><br>Census Bed Type:<br>SNF/NF: 39<br>NF: 97<br>Residential: 143<br>Total: 279<br><br>Census Payor Type:<br>Medicare: 13<br>Medicaid: 96<br>Other: 27<br>Total: 136<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed October 1, 2024. | F 0000 | The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review. | |
| F 0689<br>SS=D | 483.25(d)(1)(2)<br>Free of Accident | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Shannon Logan | Administrator | 10/10/2024 |

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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| Bldg. 00 | Hazards/Supervision/Devices<br>Based on observation, interview, and record review, the facility failed to provide supervision to prevent a cognitively impaired resident who resided on a secured memory care unit from walking out of the facility for 1 or 3 residents reviewed for elopements. (Resident B)<br><br>Finding includes:<br><br>On 9/25/24 from 9:25 a.m. until 9:30 a.m., observed the North 33 exit door on the secured memory care unit that led outside to a courtyard. The glass exit door was unlocked by CNA 1 using a button behind the nurse's station. The courtyard was enclosed by a brick privacy fence with a wooden door. The wooden door had a deadbolt lock and a shiny silver metal latch with another lock. Outside the wooden door was a set of concrete stairs that led down to a sidewalk and then to the parking lot. The parking lot was approximately 60 feet from a street in an independent living neighborhood on the facility's property. At that time, CNA 1 indicated Resident B had a history of exit seeking behaviors. The staff supervised him more often. When Resident B tried to elope in the past he told staff he was going to work.<br><br>During an interview on 9/25/24 at 11:47 a.m., the Maintenance Director indicated the lock on the wooden door in the courtyard was working prior to Resident B walking out to the parking lot. The wooden door should never be unlocked.<br><br>During an interview on 9/26/24 at 8:42 a.m., the Administrator indicated her understanding was, on 9/9/24 at approximately 5:45 a.m., Resident B told CNA 2 he had to go to work. CNA 2 explained that Resident B didn't have to go to work and that she would get him some coffee after she finished | F 0689 | F689 – Free of Accident Hazards/Supervision/Devices<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>No other residents were affected. Resident B was assessed and sent to JMH ER for further evaluation and treatment. At the ER, Resident B was noted to have abrasions to bilateral elbows, forehead, and bruises to knuckles on the right hand. The ER performed a CT scan of head/brain, spine, pelvic, and chest X-rays – no issues noted. Resident B was put on 15-minute checks. The interior door was tested for proper activation of mag lock. The exterior gate lock was checked for proper working order. An updated elopement risk assessment was completed for Resident B, and the care plan was updated to reflect “High Elopement Risk.” An assessment of Resident B’s daily engagement/activity care plan was performed and modified to provide more purposeful activities. Unit Manager educated staff on Wander/Elopement Policy.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be** | 09/27/2024 |

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| | with another resident. When CNA 2 was finished working with the other resident, the phlebotomist was on the unit looking for another resident. CNA 2 helped the phlebotomist find a resident and that was when CNA 2 noticed Resident B was not in his room and reported to the nurse. Meanwhile, at approximately 5:50 a.m., the facility received a phone call that a person had fallen in the parking lot. The night supervisor and another nurse walked outside to see what happened. Resident B was on the ground in the north parking lot and was sent to the hospital.<br><br>On 9/25/24 at 10:00 a.m., the Administrator provided the facility investigation into Resident B's elopement. The investigation included, but was not limited to:<br><br>An undated witness statement indicated, at 6:00 a.m. CNA 2 informed Licensed Practical Nurse (LPN) 1 that a resident was missing. CNA 2 picked up a phone and immediately began searching rooms and called the supervisor. CNA 2 was informed that Resident B had fallen outside in the parking lot. The door to the courtyard did not latch when LPN 1 pushed the button at the beginning of her shift and found the wooden door open upon further investigation.<br><br>An undated witness statement indicated at approximately 5:30 a.m., Resident B told CNA 2 that he had to go to work. CNA 2 explained that Resident B did not have to go to work. CNA 2 went back to the resident she was assisting. The phlebotomist was looking for another resident, so CNA 2 took the phlebotomist to that resident. CNA 2 noticed Resident B wasn't in his room and had begun looking in the common area and dining area. CNA 2 notified the nurse. Then called another unit and was told a resident was found in | | **taken?**<br>All residents who reside on MSC have the potential to be affected. A head count was completed on 9/9/2024 for all residents. The Nursing Staff completed a new elopement assessment on all MSC residents and updated as determined. When wandering behaviors occur, staff will engage in purposeful activities to deter the behavior.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br>Any noted similar behaviors will be managed according to policy. The Unit Manager began MSC Courtyard/Door Security and Elopement education to MSC staff on 9/9/2024. Doors and locks were check for proper working order. Routine door and alarm checks have been added to nursing daily duties.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>Monitoring of elopement risk and interventions is ongoing. Audits to ensure exterior door is locked and secured by 8 p.m. began on 9/9/2024. Audits will be completed for 4 weeks, then at the discretion of the QA/QAPI | |

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| | the parking lot.<br><br>A witness statement, dated 9/9/24, indicated RN 1 followed the night supervisor to the northside parking lot for a report of a person down on the ground. Upon observation and assessment, it was determined to call 911. When RN 1 returned to the unit, he informed CNA 2 that she needed to go to the parking lot to see if Resident B was the person on the ground.<br><br>The clinical record for Resident B was reviewed on 9/25/24 at 10:11 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and osteoporosis.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 7/10/24, indicated Resident B was severely cognitively impaired.<br><br>A care plan, dated 2/20/23, indicated Resident B was an elopement risk related to impaired safety awareness. Interventions included, but were not limited to, distract Resident B from wandering by offering pleasant diversions, structured activities, food, conversation, television, books Resident B prefers, and reside on secured unit for increased safety.<br><br>A care plan, dated 3/7/23, indicated Resident B had at times placed all his belongings on his bed, had stated he was going home, and he needed to go to work. Interventions included, but were not limited to, provide emotional support as needed and offer activities of interest such as listening to his favorite music.<br><br>A progress note, dated 9/9/24 at 7:00 a.m., indicated Resident B was up wandering before breakfast. Resident B told CNA 2 he was going to | | Committee. Weekly assessment of Resident's care plan at Risk Meeting for 4 weeks, biweekly for 4 weeks, and then at the discretion of the QA/QAPI Committee. The Unit Manager of MSC will bring audits to the Quality Assurance Meeting. The QA Committee will identify any trends or patterns and make recommendations to revise the process as indicated. The DON and Unit Manager are responsible for the implementation and monitoring of this plan.<br>**By what date the systemic changes for each deficiency will be completed?**<br>9/27/2024 | |

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| | work. While CNA 2 and LPN 1 were in another resident's room providing assisting, Resident B exited the unit through the door to the courtyard. After entering the courtyard, Resident B opened the gate and entered the employee parking lot where he fell. The night supervisor assessed Resident B and called 911.<br><br>An Interdisciplinary Team (IDT) note, dated 9/10/24 at 10:00 a.m., indicated the IDT met to discuss the fall and elopement.<br><br>On 9/25/24 at 10:08 a.m., the Administrator provided a copy of a facility policy, titled Elopement, dated 11/6/19, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility that all necessary steps were taken to protect elders from the risk of elopement.<br><br>This Federal tag relates to Complaint IN00442884.<br><br>3.1-45(a)(2) | | | |