STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(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 Complaint IN00419004. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00419004 - Federal/State deficiency related to the allegation are cited at F689. Survey dates: October 10, 11 & 12, 2023 Facility number: 000124 Provider number: 155219 AIM number: 100266730 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 1 Medicaid: 63 Other: 18 Total: 82 This deficiency reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 10/20/2023.	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 §483.25(d)(2)Each resident receives adequate	F 689		

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

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F 689	Continued From page 1 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to supervise a resident, with severe cognitive deficits and wandering behaviors, from exiting the facility resulting in the elopement of Resident J. The immediate jeopardy began on 10/3/23 when the facility failed to ensure supervision was provided to Resident J, who was deemed high risk for an elopement, had a diagnosis of Alzheimer's disease and displayed exit seeking behaviors. As a result, the resident was able to exit the facility unattended. The Interim Administrator, Director of Nursing Services, and Regional Nurses were notified of the immediate jeopardy, at 12:21 P.M. on 10/11/23. The immediate jeopardy was removed, and the deficient practice corrected, on 10/4/23, prior to the start of the survey and was therefore Past Noncompliance Finding includes: On 10/10/23 at 11:21 A.M., a review of the clinical record for Resident J was conducted. The resident's diagnoses included, but were not limited to: Alzheimer's Disease, schizoaffective disorder, anxiety and seizure disorder. An Annual MDS (Minimal Data Set) assessment, dated 9/18/23, indicated the resident had severe dementia, used a wheelchair and no motion sensor or wander elopement alarm. A Quarterly Wandering/Elopement Risk	F 689	Past noncompliance: no plan of correction required.	

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Assessment, dated 8/2/23, indicated the resident's score was 13. A score of 11 or higher indicated resident was a high risk for an elopement.

A Psychiatrist Progress Note, dated 8/31/23, indicated the psychiatrist observed the following "...adaptive weaknesses, distressing delusions of persecution, e.g., someone is coming to get her, she is pregnant, a significant other is dead, President Carter is to blame, etc. Ongoing, agitation, cursing, shouting at staff or reticent to speak, aggression, anxiety, and irritability/lability. At previous placement, resident physical aggression has been reported to cause $20K for repair in destruction of equipment and facility property. At the present encounter, writer observed resident while waiting for lunch as guarded, reactive and defensive, inquired, ?who are you? before writer began introduction. Stated, ?I don?t talk to psychologist! Bye!? Showed oriented to person... Mental status is severely impaired...."

A care plan, dated 4/5/23 and last updated on 7/13/23, indicated the resident had behavioral symptoms of wondering and exit seeking. The interventions included, but were not limited to: identify behavior triggers, reduce exposure to triggers, maintain a safe environment and offer diversional activity.

Another care plan, dated 10/20/21 and revised on 7/13/23, indicated the resident exhibited signs of cognitive impairment due to diagnosis of Alzheimer's and Dementia. Interventions included, but were not limited to: provide resident with cues-reminders to assist with decision making and recall. Be alert to non-verbal cues of

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problems or unmet needs.

A Behavior Monitoring form indicated the resident was having "Behavior Symptoms" of wandering, on 9/9, 9/10, 9/11, 9/24 and 10/3/23 at 10:12 A.M.

A self-reported incident #331, dated 10/3/23, regarding Resident J indicated " ...On 10.3 at approximately 4:00 pm resident wheelchair was observed by staff in the front of the lobby without the resident. Staff member notified the Nurses and a "Code Walker" was initiated. Staff Notified the ED/DNS [Executive Director/Director of Nursing Services] and continued search inside the facility, ED /DNS immediately arrived at the facility and notified police and continues search on the parameter of the facility. The weather outside was clear and warm. The outside search continued without results. A headcount revealed that all residents were accounted for except [name of resident]. [Name of Resident] has last been observed by DNS and Activity Director at 330 pm. She had been sitting outside for fresh air which was her typical behavior. Staff notified ED and DNS an interview with another resident revealed that the resident was observed getting into a " Cab" and was informed that the resident was taken to the store .3 miles from the facility. The DNS, ED and Activity Director took picture of the resident to the store and the clerk verified that the resident had been at the store. While at the store the DNS received a call from the police that the resident was picked up at the store and taken by EMS to [name of hospital]. ED spoke to nurse at the ER [Emergency Room] and the resident was there and had no signs of physical injury after assessment by ER staff. Resident was returned to the facility ...."

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A typed statement, dated 10/4/23 at 2:48 P.M., signed by the Social Service Director (SSD) indicated she had observed the resident sitting in her wheelchair, outside, and had refused to return, inside the facility.

A written statement, undated, by Administrative Assistant, who sits at the main entrance, indicated "...On Oct 3rd around lunch time Resident [name of resident] was sitting up here at the desk/lobby area for a hour or 2. She asked to go out, and I nicely told her that I couldn't let her out. She got mad and held the door for 15 secs [seconds] and walked out and went to the sitting area. She was outside for a while and then came back in for her wheelchair. [Name of Resident] then proceeded to go back outside with her wheelchair and sat back down...."

A typed statement by the Director of Nursing Services (DNS), dated 10/3/23 at 5:30 P.M., indicated "...Name of Resident J] walked through front after holding door for 15 sec [seconds] sat at the sitting area outside the facility about 11am. This writer and SS [Social Services] attempted to redirect Resident to back in facility Resident declined stating I am trying to get fresh air...Resident continue sitting outside for the rest of the time. At 3:30pm this writer again noted this Resident sitting outside at the same spot...."

During an interview, on 10/10/23 at 11:30 P.M., the Psychiatric Services Nurse Practitioner (NP) indicated she had seen the resident approximately every 2 weeks since July of 2023. She indicated the resident usually sat in a wheelchair, but could walk when she wanted to. The NP indicated the resident sat at the front entrance but had never communicated to her,

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she wanted to leave the facility. The NP indicated the resident would not have been safe left unattended and by herself outside of the community. The NP indicated the resident had delusions, stating she was seeing people and hearing voices. NP indicated she had to be sent to a psychiatric hospital due to her psychotic state, for stabilization after the elopement incident.

During an interview, on 10/10/23 at 1:17 P.M., the SSD, indicated she was with the Resident J while she was sitting outside, in a sitting area, for approximately 1.5 hours. The Front Desk Receptionist sat with the resident afterward. The SSD explained she left the building, at approximately 2:45 P.M., and observed the resident, sitting outside, with the Front Desk Receptionist. As the SSD was leaving the facility the DNS was approaching the area, where the resident was sitting.

During an interview, on 10/10/23 at 1:28 P.M., the DNS indicated the resident had exited out of the building, by holding onto the exit door for 15 seconds and the locked door released. The DNS had observed the resident leave the facility. The DNS indicated she, along with the Marketing/Admission Coordinator and the SSD had tried to get the resident to return inside the facility, but the resident declined and went to an area, outside the facility where there were chairs and a table with an umbrella. The DNS indicated she instructed the Marketing/Admission Coordinator to stay with the resident. She had observed the resident, again through the glass door at approximately 3:30 P.M. but didn't notice if anyone was with her. She left the facility at approximately 3:45 P.M., and noticed an empty

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wheelchair where the resident had been sitting and assumed Resident J had returned inside of the facility.

During an interview, on 10/10/23 at 1:42 P.M., the Front desk Receptionist/Administrative Assistance indicated the resident had been sitting at the front entrance for approximately 1-1.5 hours around noon time. The resident then asked to go outside, however she explained to the resident she could not allow her out, so the resident pushed on the door, the alarm sounded, and the door then opened (had an emergency unlock after 15 seconds of pressure on exit door) and the resident wheeled herself out the door. At that time she verbally told the SSD and she went outside with the resident.

On 10/10/23 at 1:59 P.M., an interview was conducted with the Administrator, the DNS, the SSD, the Activity Director and the Marketing/Admission Director. The Marketing/Admission Director indicated she went outside to relieve the SSD and sat with the resident for approximately 30 minutes, when the resident was persuaded to return inside the facility for a drink. The Marketing/Admission Director indicated the resident was in her wheelchair and was last observed heading toward the dining room, at approximately 3:00 P.M. The Administrator indicated he was never outside with the resident and was not involved prior to discovery of elopement. The Activity Director indicated, at approximately 3:00 P.M., she had observed the resident, through a glass window, sitting in her wheelchair, at another area, near the gazebo. None of those present, during the interview, had any idea how the resident got out of the facility the second time.

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During an interview, on 10/10/23 at 2:46 P.M., the Front desk Receptionist/Administrative Assistant indicated she was the person who worked the front desk on 10/3/23 from 8 A.M. through 4:00 P.M. and had not observed the resident and/or Marketing/Admission Director return inside the facility, nor did she observe or hear an alarm indicating the resident had left the building after 3:00 P.M.

The SSD indicated, on 10/10/23 at 3:06 P.M., if there were wander seeking behavior notes, they would be in the Progress Notes. She indicated she had not written a progress note regarding the resident's exit seeking behavior that day.

During an interview, on 10/10/23 at 3:35 P.M., LPN 2, who worked the resident's unit, indicated she was not aware of Resident J being outside for several hours and not wanting to return to the unit, until the staff were notified of the elopement.

During an interview on 10/11/23 at 10:05 A.M., the Administrator indicated the cab company was called and indicated they left the Resident J at the store. The resident told the cab driver she would pay for the cab fare once she got to the store and used an ATM machine. The cab company indicated the resident ran into the store and would not pay the cab fare, so they left her there. He indicated the police notified him the resident had been picked up, at the store, and taken to a local emergency room.

An Emergency Room (ER) Report, dated 10/3/23 at 4:04 P.M., indicated the resident presented to the emergency department with aggressive behavior. Report indicated the resident was

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found, on the floor, at a smoke shop and 911 was called. The medics evaluated the resident and chose to bring her to the ER for an evaluation. An ER Medical Decision Making Note indicated " ...Patient presented to the ED [Emergency Department] for an evaluation. She arrived via EMS. It turns out that she resides in a place called [name of facility]. We were able to contact them and they indicated she had eloped from their facility earlier in the day. Apparently she walked from there to a liquor store and the liquor store called 911 and she was subsequently brought in by EMS. In the ED she required sedation ...The patient will be transferred back to her facility by the medics ...."

On 10/12/23 at 10:27 A.M., the Administrator provided a policy titled, "Elopements and Wandering Residents", dated 4/6/19 and revised 9/23, and indicated the policy was the one 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 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...4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering...d. Adequate supervision will be provided to help prevent accidents accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly...."

The past noncompliance immediate jeopardy began on 10/3/23. The immediate jeopardy was removed and the deficient practice corrected by

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F 689	Continued From page 9 10/4/23 after the facility implemented a systemic plan that included the following actions: all current residents elopement evaluation scores were reviewed, care plans updated, elopement binder reviewed/updated, doors codes changed, wanderguard systems tested, elopement drills and all staff educated on the elopement policy. This Federal tag relates to complaint IN00419004. 3.1-45(a)(2)	F 689		