STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155236	A. BUILDING 00 B. WING	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVON HEALTH & REHABILITATION CENTER	4171 FOREST POINTE CIRCLE AVON, IN 46123

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00391937, IN00392507, IN00393626, IN00394231, and IN00399010. Complaint IN00391937 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00392507 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00393626 - Unsubstantiated due to lack of evidence. Complaint IN00394231 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00399010 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 17, 18, and 19, 2022 Facility number: 000141 Provider number: 155236 AIM number: 100283860 Census Bed Type: SNF/NF: 118 SNF: 2 Residential: 26 Total: 146 Census Payor Type: Medicare: 15 Medicaid: 73 Other: 32 Total: 120	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Brummitt	RN,DCS	02/06/2023

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 26, 2023.			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §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 supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure management and oversight of a confused resident resulting in elopement of 1 of 4 residents reviewed for wandering and exit seeking behaviors (Resident B). Using the reasonable person concept, it is likely that this would lead to mental anguish including anger, distrust, and chronic or recurrent fear and anxiety. Findings include: An Indiana State Department of Health Survey Report System report, dated 10/6/22 at 6:01 a.m., indicated Resident B was found in the employee parking lot. Resident assessed by Nurse Practitioner, noted to possibly have delirium related to hospitalization, surgery, and anesthesia. On 1/18/23 at 9:10 a.m., observation of the staff service hallway located midway down the 500 hallway. The door providing access onto the	F 0689	The facility will ensure this requirement is met through the following corrective measures: 1. Resident B was not harmed. He remained under direct supervision by family and went LOA for a doctor's appointment from which he was admitted to the hospital. Please note: resident B had family with him from the time he admitted, through the night and until the following evening. The resident had not been up ambulating during that time. 2. All residents at risk for elopement and not residing in the memory care unit have the potential to be affected. Elopement risk assessments have been reviewed to ensure all those at risk are identified. The second exit door was repaired directly	02/10/2023

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	service hallway equipped with a keypad lock was observed to be ajar and visitor was able to access the hallway. A regional maintenance worker indicated the door was not closing properly and would be looked at. The first exit door on the left in the service hallway that provided direct access to the generator and back employee parking lot was observed to have a keypad lock. Housekeeper 13 indicated the keypad lock had recently been installed on that exit door to the parking lot. On 1/18/23 at 9:29 a.m., a second observation of the door providing access to the 500 hallway service hallway observed to be standing ajar. Observation of 2 unidentified staff members going through the door from service hallway, lag time for the door to close and secure was approximately 15 - 30 seconds. The regional maintenance worker indicated he and a crew had entered the facility on Monday 1/16/23 to provide general maintenance to resident rooms and noticed at that time the service doorway was not closing properly, and he had made the facility aware. On 1/18/23 at 9:40 a.m., together with Certified Nursing Assistants (CNAs) 7 and 9, the Assistant Director of Clinical Services (ADCS) was observed exiting the service hallway then walking down the 500 hallway towards the nurses' station. The door opening onto the service hallway was observed to not close completely or latch. On 1/18/23 at 9:50 a.m., contracted construction worker 17 was observed on a ladder at the entry of the employee service hallway. He indicated positive air pressure was the cause of the door not closing or not closing timely and locking. The first exit door on the left in the service hallway facing the employee parking lot and generator had		after the incident with the addition of a key pad. The service hall exit door has been repaired with adjustment of the return arm, the electrical supply to the latch was repaired and restored, and an alarm was added. 3. Those policies were reviewed and no changes are indicated. Facility staff will be re-educated on the elopement risk policy and process to submit a work order. The HFA or her designee will round twice daily for 6 weeks to ensure door closure systems and alarms are functioning appropriately for 6 weeks and until 100% compliance is achieved, then twice weekly for 6 months and until 100% compliance is maintained. 4. The findings of these rounds will be presented during the facility's monthly QAPI meetings and the plan of action altered accordingly.	

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	not been locked or had an audible alarm until he had recently installed the keypad lock and alarm over the door. Before the door could be opened just by pushing the bar on the door. Accessing that door could have set off an alarm at the nurse's station, but he was not sure. Contracted construction workers 17 and 18 demonstrated opening the exit door and an alarm sounding in the nurse's station with the button lighting up on the panel. Contracted construction worker 18 demonstrated how to reset the alarm button, then demonstrated how by pushing any button on the alarm panel, the alarms could be silenced on any access doorway to include the door in question on the service hallway. Contracted construction worker 17 indicated the service door from the 500 hallway now had a keypad but no alarm, so anyone could access the service hallway with the code and no alarm would sound. The ADCS indicated this was most likely due to frequent staff traffic in and out. Resident B's record was reviewed on 1/17/23 at 11:37 a.m. Diagnoses on Resident B's profile included, but were not limited to, surgical aftercare, mitral valve disorders, atrial fibrillation (rapid and irregular heart beating), hypertension (high blood pressure), muscle wasting and atrophy, abnormalities of gait and mobility, lack of coordination, need for assistance with personal care, and cognitive communication deficit (difficulty with thinking and how someone uses language). A physician's order, dated 10/5/22, indicated strict sternal precautions (i.e., don't push or reach out with both arms) for 6 weeks. A physician's order, dated 10/5/22, indicated may go out on leave of absence (LOA) with			

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	responsible party and meds. An admission assessment, dated 10/5/22 at 5:21 p.m., indicated Resident B was alert to person, lethargic and questioning, his mood passive and comprehensive slow. The resident ambulated independently with no assistive devices and had no fall history. An initial care plan addressed potential for bleeding, pressure ulcers and falls. There was no documentation that addressed potential for elopement. A Quarterly Risk Evaluations, dated 10/5/22, indicated a score of 8 and moderate risk for falls. The resident had the ability to move about the facility independently and demonstrated poor judgement/impaired safety awareness. No history of wandering. An intra-facility transfer form, dated 10/6/22, indicated resident relocated from the skilled unit to the secured memory care unit. The move was necessary for the welfare of the resident or other persons. Responsible party waived the 48 hour notice and relocation planning conference. The resident record lacked documentation the resident was moved back out of the secured memory care unit to his original room on the skilled unit. A late entry notes by Nurse Practitioner (NP) 20, created on 10/11/22 at 12:50 a.m., effective 10/6/22 at 12:50 a.m., indicated the resident was admitted to the facility secondary to deficits in mobility and activities of daily living (ADL's). Nursing notes that the patient was found outside the building wandering earlier today and had had episodes of increased confusion and agitation. Family notes that the patient did have delirium after surgery without much improvement. Patient continued to have confusion at this facility and was found			

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	wandering outside and at times could be agitated. Family stated that they did not want the patient in the dementia unit. Accommodations were made so that the family could stay with the patient 24 hours a day in a private rehab room. A late entry nurse's note by the Assistance Director of Clinical Services (ADCS) created on 10/6/22 at 12:40 p.m., effective 10/6/22 at 7:00 a.m., indicated she was notified by nursing staff at 6:09 a.m. Resident B had been found by staff in the employee parking lot at shift change. Resident was brought in by staff and placed on secure memory care unit for breakfast until he could be assessed for proper placement. ADCS was informed the resident had been at the nurse's station at approximately 5:00 a.m. and was redirected back to his room. Family stated there had been a change in the resident's mentation from the previous day. They did not want to send resident out for evaluation and felt that it was probably from all the changes. Family requested the resident move out of the secure memory care unit back to his prior room, and that family would provide 1 on 1 with him until mentation improved or the resident discharged to home. A nurses note dated 10/7/22 at 8:41 p.m. daughter called and stated the resident was taken from a doctor's appointment to the emergency room (ER) and was being re-admitted to the hospital. A Medicare 5 day Minimum Data Set (MDS) assessment completed on 10/7/22, indicated Resident B had the ability to make himself understood and to understand others. A Brief Interview for Mental Status (BIMS) score of 3 indicated severe cognitive impairment. No signs or symptoms of delirium, behaviors, rejection of			

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	care, or wandering. Extensive assistance of 1 person physical assist for bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, dressing, toilet use, and personal hygiene. Mobility devices included a wheelchair and walker. A handwritten witness statement by staff member 6, dated 10/6/22, indicate, "Pulling in the parking lot at 6 am. As I was walking in I seen a resident being walked back to the building. [CNA 9] was escorting him back." A handwritten witness statement by Licensed Practical Nurse (LPN) 8, dated 10/6/22 at 6:00 a.m., indicated, "I saw 1 staff member arm in arm with resident. They were walking from in between cars in south parking lot going towards the 500 hall door. They entered the door and assisted resident into a wheelchair. Staff immediately notified supervisors and directed to take resident to 400 hall. Resident complied without issues." A handwritten witness statement by CNA 9, dated 10/6/22, indicated, around 6:00 am on Tuesday 6th of Oct he was called by his wife who dropped him off at work, said she saw someone maybe staff or resident walking from the parking lot. "Look was and after clock in at 6:00 am I went back outside to see what was going on and I talk to this man and I bring him to the building before I knew he was one of the residents." E-mail correspondence between the facility and the Regional Director of Operations, included pictures and descriptions to include, a. Picture of electronic panel with note, "Door is alarmed but the alarm was silenced." b. Picture of a door, "This is the door that should have a keypad added."			

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	c. Picture of a door, "This door had an automatic opener that is very slow and leaves the door open for several seconds." d. Picture of Evacuation Plan on the wall, "The service hallway on the evacuation plan is the area that the door is located that the resident exited." A memo posted by an alarm panel in the nurse's station, signed by the Executive Director (ED), indicated, "These alarms are to always remain on! If they are found to be turned off, disciplinary action up to and including termination will occur." A work order, created 10/6/22 at 12:00 p.m., updated 10/16/22 at 11:06 a.m., indicated the service door going to the generator needed a keypad installed. This was from an elopement in the building. The Maintenance Supervisor indicated the keypad was installed between 10/10/22 and 10/12/22. A list of residents known for wandering included documentation of six (6) residents, 2 of which continued to reside on the 500 hallway, Residents F and G. During an interview on 1/18/23 at 9:15 a.m., Housekeeper 13 indicated the first exit door on the left in the service hallway recently had a keypad lock applied. If the wrong code was entered an alarm was supposed to sound at the nurse's station. During an interview on 1/18/23 at 9:23 a.m., CNA 7 indicated, the door leading onto the service hall had not closed properly for a couple of years, staff had repeatedly reported the door to management, and Resident B was not the first resident to go out that door. The night Resident B eloped, he had wanted to go outside to smoke,			

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	and the night shift staff did not routinely take residents out to smoke. To her knowledge, CNA 9's wife had seen Resident B near a gate to a nearby housing addition just standing outside. She had thought there was snow on the ground at that time and was unsure if the resident had a coat on. Resident B had to have gone thru the service door that did not latch and then out through the side exit door on the service hallway that was not alarmed. There was a paved sidewalk straight to the back parking lot towards a newer housing addition. During an interview on 1/18/23 at 9:30 a.m., CNA 9 indicated on 10/6/22 his wife had dropped him off at work at 6:00 a.m. He entered the facility to clock in and his wife called, indicated when she turned around and was coming back by the employee entrance her headlights spotted a gentleman crossing the parking lot road and walking onto the grass near the back yard of a nearby housing addition. CNA 9 went back outside and with the help of his wife backing up and turning her car headlights towards the housing addition was able to see a man underneath some trees on the grass. CNA 9 was not sure if the gentleman was a resident or not but assisted him from behind the trees, down across the grass, through the parked car, and into the facility and helped him into a wheelchair and took him to the nurse's station. A night nurse identified Resident B as a new resident from the prior evening. The resident was dressed in a short sleeved red button-up t-shirt with no coat carrying a small bag, and it was cold outside. CNA 9 indicated he was not sure how long the resident had been outside or how he got out but speculated the service door had not latch with staff going through to either take out the trash or laundry and the resident went out the unsecured exit door on the service hallway that			

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	was a straight path to where he was found in the trees. Resident B seemed confused, and when asked if he was okay, replied he was "not doing good and I'm tired." Indicated after the resident was found outside, he was initially placed on the secured memory care unit, but the family did not want him to be back there, so he was returned to the 500 unit room. The plan was for family to 1:1 with the resident, but they would stay periods of time then leave. CNA 9 acknowledged Resident B was found near the neighboring housing addition, hidden in the trees in the dark, confused, and if his wife had not found the resident he could have walked away and got to the road or highway nearby without anyone knowing where he had gone. During an interview on 1/18/23 at 9:53 a.m., the ADCS indicated she did not have prior knowledge of the service door not consistently latching. Indicated on 10/6/22 she was told at around 5:00 a.m. Resident B had been seen at the nurse's station and staff redirected him back to his room. When day shift started arriving around 5:30 a.m. - 6:00 a.m. the resident was observed by the employee entrance. She thought Resident B had gone through the service door that was slow to close after an employee had gone through. The resident then got out of an unlocked exit door on the service hallway. All the exterior doors of the building when opened would alarm at the nurse's station, and the alarm panel at the nurse's station was found to have been silenced that night. The resident was supposed to have assistance with ambulation but would walk around independently. Family indicated Resident B lived alone before surgery, but after surgery his mental status was totally different, even from the day before a lot different.			

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	During an interview on 1/18/23 at 9:57 a.m., the Maintenance Supervisor indicated, he was not made aware of issues with the service door not latching until that today. Upon review, he had no maintenance slips regarding the service doors from January 2022 to present. During an interview on 1/18/23 at 10:32 a.m., the Regional Nurse indicated, the alarm in the nurse's station had sounded on 10/6/22, but there were no nurses in the nurse's station and the alarm was not loud enough to be heard on the hallways. There had always been a maglock alarm (locking device that consists of an electromagnet attached to the doorframe that bonds to an armature plate on the door when shut) on the exit door down the service hallway that faced the parking lot by the generator, but the keypad was new. During an interview on 1/19/23 at 9:56 a.m., Licensed Practical Nurse (LPN) 19 indicated when anyone accessed any hallway exit door, a loud alarm would sound in the nurse's station from a panel on the wall. A button would light up on the panel to indicated which door was opened. Staff were to go to the door and visualize to see who set it off, and not just turn off the alarm until a determination made was it not a resident outside. On 1/17/23 at 3:00 p.m., the Director of Clinical Services (DCS) provided an Elopement/Missing Resident Policy, revised 10/22, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the responsibility of all personnel to report a cognitively impaired resident found outside the facility or attempting to leave the facility to the change nurse immediately...Facilities are responsible for identifying and assessing a resident's risk for leaving the facility without			

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	notification to staff and developing interventions to address the risk...." Using the reasonable person concept, it is likely that this would lead to mental anguish including anger, distrust, and chronic or recurrent fear and anxiety. This Federal tag relates to Complaint IN00391937. 3.1-45(a)(1) 3.1-45(a)(2)			