STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN HEALTH CARE	140 W WASHINGTON ST MORGANTOWN, IN 46160

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00431134. This visit resulted in a Partially Extended Survey- Substandard Quality of Care-Immediate Jeopardy. Complaint IN00431134 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: March 26, 27, and 28, 2024 Facility number: 000399 Provider number: 15E683 AIM number: 100289100 Census Bed Type: NF: 31 Total: 31 Census Payor Type: Medicaid: 23 Other: 8 Total: 31 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 3, 2024.	F 0000		
F 0689 SS=J 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			

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

Michelle Russell | Interim Administrator | 04/21/2024

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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	§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 provide adequate supervision to prevent a resident with a history of elopement from walking out the same emergency exit door on 3 consecutive days for 1 of 3 residents reviewed for elopement. Resident B was found 1.1 miles in an empty commercial lot by the police. (Resident B) The Immediate Jeopardy began on March 23, 2024, when Resident B exited the facility without staff supervision. The Administrator and the Vice President of Clinical Operations were notified of the Immediate Jeopardy, on March 27, 2024 at 10:45 a.m. The Immediate Jeopardy was removed, on 3/28/24 at 4:45 p.m., but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: On 3/26/24 at 7:02 a.m., Resident B was observed lying in bed resting. Resident B was not on 1-on-1 (continuous) supervision. During an interview on 3/26/24 at 7:05 a.m., CNA 1 (Certified Nursing Aide) indicated CNA 1 knew Resident B had left the facility on 3/23/24 (Saturday) on evening shift. Resident B left the facility again, on 3/25/24 (Monday) on evening shift. Resident B was not on 1-on-1 supervision when CNA 1 arrived at the facility, on 3/25/24 at approximately 11:00 p.m., nor was Resident B on 1-on-1 supervision during night shift, from 3/25/24 at approximately 11:00 p.m. until 3/26/24 at approximately 7:00 a.m., when CNA 1 left work.	F 0689	Morgantown Woods of Journey Plan of Correction Complaint Event ID: IN431134 Exit Date 3/28/243 F689 Free of Accidents and hazard/supervision – Focus – Resident # 3 Element I Resident R#3 no longer resides at this facility. Element II Residents currently residing in the facility that are at risk for elopement are considered like residents. An audit of current residents residing in the facility was completed on 3/23/24 by the charge nurse to ensure current residents were safe and accounted for. An audit to ensure exit door alarms were in working order was completed by the maintenance department on 3/24/24 and daily thereafter and reviewed by the administrator. All were found to be functional. An audit of current residents at risk for elopement was completed by the DON on 3/23/24 to ensure residents had an elopement risk review completed within 90 days. An Elopement Prevention Care Audit tool has been completed on 3/23/24 by the DON, to include: 1 placement, function, and	04/22/2024

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	On 3/26/24 at 7:07 a.m., the emergency exit door in the dining room was observed. The emergency exit door was shut and had a keypad to the right of the door. The small, battery operated, door alarm was not observed on the door nor the door frame. The door led out to a front porch that was not secured. The porch was approximately 15 feet from a busy main street. There were cars parked on each side of the street which caused poor visibility to see oncoming traffic. During an interview on 3/26/24 at 7:35 a.m., the VPCO (Vice President of Clinical Operations) indicated, on 3/23/24 at an unknown time, Resident B walked out the emergency exit door in the dining room, at the front of the facility. The alarms did not sound because that door was not connected to the internal alarm system, but did have a small, battery operated, generic alarm that would sound like a doorbell if the door was opened. The staff received a call from the county police department, on 3/23/24 at approximately 10:27 p.m., and asked if Resident B was a resident at this facility. Resident B returned to the facility accompanied by police, on 3/23/24 at approximately 10:35 p.m. The officer reported to the nurse that Resident B said he was just getting fresh air and wanted to go to Indianapolis to visit his mother. When Resident B returned to the facility with the police, Resident B was placed on 15-minute checks. The VPCO had just been informed that Resident B walked out the same emergency exit door, on 3/24/24 (one day after the initial elopement), and again, on 3/25/24 (two days after the initial elopement). Resident B eloped in July of 2023 as well. The staff should have notified the VPCO when Resident B left the facility each time. The information regarding the elopements on 3/24/24 should have been		expiration date of alarms. 2 elopement risk review in place. 3 care plan developed and implemented. 4 care delivery policy reviewed. 5 appropriate assessment and intervention 6 evaluate for condition/behavioral changes. An audit was completed on 3/23/24 of the elopement book to verify that all residents at risk for elopement had an elopement photo sheet in place. Rounds have been completed by nurses, and CNA to identify any residents with behavior / condition changes that may affect their risk for elopement. Element III Door watch system is in place to monitor the Dining Room door on 3/23/24. The door was fixed on 3/24/24 by Safe Care and a new door and casing has been ordered. The door alarm company checked the function of all exit doors and attested they were functional on. New door alarms purchased to have extra when an issue arises. Daily door checks were initiated with all alarmed doors identified which requires a signature attesting to functionality. These reports are reviewed by the Administrator or designee on the next business day. Any malfunction of an alarm is reported	

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	documented by the DON (Director of Nursing) and the elopement on 3/25/24 should have been documented by the agency nurse. Resident B should have been on 1-on-1 supervision to prevent the elopements. During an interview on 3/26/24 at 8:35 a.m., Resident B indicated he went outside over the past few days to get fresh air and walk. During an interview on 3/26/24 at 9:49 a.m., LPN 1 (Licensed Practical Nurse) indicated LPN 1 was the nurse that worked evening shift, on 3/23/24 from 7:00 p.m. until 7:00 a.m. LPN 1 received a call from the county police dispatch, on 3/23/24 at approximately 10:25 p.m. The police dispatcher asked if Resident B lived at this facility. The police dispatcher indicated Resident B was found by police approximately 1.1 miles from the facility walking in an empty commercial lot on Highway 135. LPN 1 verified Resident B was returned to the facility by police, on 3/23/24 at approximately 10:35 p.m. Resident B indicated to LPN 1 and the police officer that Resident B just wanted to walk, get fresh air, and go see his mother in Indianapolis. Resident B was wearing pajama pants, a long sleeve dark green shirt, and non-skid socks. Resident B was not wearing shoes. Resident B had a small abrasion on the right side of his ankle, but Resident B could not remember how the abrasion happened. Resident B was immediately placed on 15 minute checks. When LPN 1 checked the emergency exit door in the dining room, LPN 1 found a small battery-operated doorbell alarm with corroded batteries inside. LPN 1 changed the batteries and resecured the emergency exit. On 3/26/24 from 11:05 a.m. until 11:17 a.m., the location where the police officer found Resident		to the NHA/Designee immediately and an employee is placed on door watch duty until function is restored. Keypads are in place at the doors and the codes were changed on 3/24/24 by the maintenance department. Key codes will be changed Monthly. The Elopement Prevention and Management Program was reviewed by the Director of Nursing and deemed appropriate. An elopement prevention audit tool will be completed weekly x 4 weeks and then monthly x 3 months. A daily door audit is completed by Maintenance for 60 days. Then weekly after new door is installed. Facility staff were re-educated by the Nursing Managers on the elopement policy including, prevention, wander control system, maintaining door alarms, immediate reporting responsibilities including changes in condition/ behavior, elopement attempts and elopements. Element IV The audits will be submitted to the QAPI committee for review and recommendations. The NHA is responsible for ensuring that implementation of the plan of correction and that compliance is in place.	

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	B, on 3/23/24 at approximately 10:25 p.m., was observed. The empty commercial parking lot was approximately 1.1 miles from the facility, located on State Highway 135. From the facility, Resident B walked approximately 0.3 miles and crossed over train tracks. After the train tracks, the sidewalks ended. At 0.4 miles from the facility, the speed limit increased to 55 miles an hour, there were no street lights, and the terrain from approximately 0.4 miles to the empty commercial parking lot was rough gravel approximately 1.5 feet wide next to the highway and tall grass and weeds. During an interview on 3/26/24 at 12:38 p.m., CNA 2 indicated CNA 2 worked evening shift, on 3/25/24 (2 days after the initial elopement). Resident B left the facility at an unknown time and returned on his own by walking to the employee entrance, on 3/25/24 at approximately 9:00 p.m. CNA 2 knew Resident B was at the employee entrance because the wander guard alarm sounded, so CNA 2 turned off the alarm, and walked Resident B to his room. Resident B was wearing sweatpants, a t-shirt, and non-skid socks. Resident B was not wearing shoes. The agency nurse told Resident B that he could not pace on the front hall near the dining room because the staff could not supervise him. After dinner, CNA 2 saw Resident B pacing up and down the front hallway near the dining room and emergency exit door. CNA 2 and an agency nurse were the only clinical staff working during evening shift, on 3/25/24. CNA 2 knew Resident B should have been on 1-on-1 with a staff member, but CNA 2 could not provide 1-on-1 supervision as other residents needed care as well. The historical weather report for the facility was reviewed, on 3/26/24 at 2:30 p.m. The AccuWeather indicated:			

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	On 3/23/24 from 8:00 p.m. until 10:30 p.m., the temperature was approximately 36 to 38 degrees Fahrenheit. On 3/24/24 from 5:00 p.m. until 5:45 p.m., the temperature was approximately 53 to 55 degrees Fahrenheit. On 3/25/24 from 7:00 p.m. until 9:00 p.m., the temperature was approximately 64 to 66 degrees Fahrenheit. During an interview on 3/27/24 at 8:04 a.m., the VPCO indicated Resident B walked out the same emergency exit door in the dining room, on 3/24/24 (1 day after the initial elopement). There were staff in the dining room, but the staff were assisting other residents. The clinical record for Resident B was reviewed on 3/27/24 at 8:40 a.m. The diagnoses included, but were not limited to, non-traumatic brain dysfunction, schizophrenia, psychotic disorder, and bilateral hand amputation. A Court Order Appointing Guardian Over Incapacitated Person, dated 8/16/23, indicated Resident B was an incapacitated person and was not unable to make health care decisions due to schizophrenia. A guardian was granted for Resident B. An Outpatient Burn Hospital Physical Therapy Note, dated 3/1/23, indicated Resident B sustained frostbite to bilateral hands, face, and heels. Resident B left his group home in the night and was exposed to extreme cold for an unknown amount of time. Resident B required bilateral wrist amputations in January 2023.			

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A Quarterly MDS (Minimum Data Set) assessment, dated 2/6/24, indicated Resident B was cognitively intact.

A care plan, dated 7/19/23 and current through 5/6/24, indicated Resident B was at risk to wander from the facility secondary to a long history of homelessness and Resident B expressed his wish to leave. The care plan was reviewed on 8/9/23, 11/7/23, 2/6/24, and 3/26/24. The care plan also indicated, on 7/24/23, "elopement" and, on 3/26/24, "care plan reviewed no changes made". Undated interventions included, but were not limited to, monitor placement of bracelet alarm and document presence and check function of bracelet alarm at the front and back doors.

An Elopement Risk Assessment, dated 7/17/23, indicated Resident B was not an elopement risk. Resident B was alert and had not had an elopement. A hand written note at the bottom of the assessment, dated 7/17/23, indicated a wander guard was to be utilized because Resident B was ambulatory and expressed a wish to return to street life.

A Psychiatric Hospital Note, dated 7/26/23, indicated per facility nursing staff Resident B "bolted" out of the dining room during dinner and ran into the street. Resident B was threatening staff. Resident B was found later by a police canine unit and Resident B reported he was walking back to his home in Indianapolis. Resident B threatened staff prior to eloping from the secure facility and Resident B reported no one wanted him to be there so he left. Resident B had a history of substance abuse and cocaine use.

An Elopement Risk Assessment, dated 8/8/23,

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	indicated Resident B was an elopement risk. Resident B had intermittent confusion and had 1 to 2 elopements. An Elopement Risk Assessment, dated 2/3/24, indicated Resident B was an elopement risk. Resident B had intermittent confusion and had 1 to 2 elopement. A progress note, dated 3/23/24 at 10:55 p.m., indicated LPN 1 received a call from police dispatch. The dispatcher indicated Resident B was found walking down State Highway 135 at 10:27 p.m. Resident B returned to the facility with a police officer. Resident B indicated he needed fresh air. The police officer indicated while in transport, Resident B indicated he wanted to go to Indianapolis to see his mother. An abrasion was noted to the front of Resident B's right ankle. Resident B couldn't remember how the abrasion happened. Resident B was placed on 15-minute checks. Resident B indicated that he ran and pushed the emergency exit door in the dining room open with his body. The emergency exit door was secured when the alarm batteries were replaced. An Elopement Risk Assessment, dated 3/23/24, indicated Resident B was an elopement risk. Physician's orders initiated, on 3/24/24 at 6:30 p.m., (after the second elopement) were as follows: 1. Increase Haloperidol (a prescription medication used to treat psychosis) tablet to 15 mg (milligrams) orally at bedtime for psychosis; 2. Increase Haloperidol decanoate (a prescription injectable medication used to treat psychosis) to 150 mg, give 1 dose when available then every 28			

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	days for psychosis and agitation; 3. 1-on-1 direct care for the next 24 hours from 3/24/24 at 6:30 p.m. until 3/25/24 at 6:30 p.m., then re-evaluate. The March 2024 behavior monitoring documentation indicated Resident B had auditory hallucinations every day from 7:00 a.m., until 3:00 p.m., except on 3/17/24 and 3/24/24. Resident B was not observed to have any auditory hallucinations on any other shifts. On 3/23/24 from 3:00 p.m. until 11:00 p.m. Resident B had exit seeking behaviors. A progress note, dated 3/27/24, indicated the elopement event from Monday, 3/25/24, was investigated. Resident B returned to facility at approximately 8:00 p.m. The clinical record did not include sufficient documentation to determine the specific details regarding elopement 1, on 3/23/24, elopement 2, on 3/24/24, nor elopement 3, on 3/25/24. During an interview on 3/28/24 at 10:50 a.m., CNA 3 indicated on 3/24/24 at approximately 5:00 p.m. CNA 3 was passing dinner trays to the residents who wanted to have dinner in their rooms. CNA 3 saw Resident B walk out to the hallway then Resident B turned and walked back into his room. Approximately 10 minutes later, Resident B wasn't in his room. CNA 3 immediately went outside and looked around the facility. CNA 3 located Resident B approximately 3 blocks from the facility walking away from the facility. When CNA 3 caught up with Resident B, Resident B indicated Resident B did not want to go back to the facility. Resident B was wearing sweat pants, long sleeve shirt, and non-skid socks. Resident B was not			

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	wearing shoes. CNA 3 brought Resident B back to the facility at approximately 5:45 p.m. The alarm did not sound when he left the facility. On 3/26/24 at 8:57 a.m., the VPCO provided a copy of a facility policy, titled Elopements and Wandering Residents, dated 2/16/24, and indicated this was the current policy used by the facility. A review of the policy indicated alarms are not a replacement for necessary supervision. This facility ensures residents at risk for elopement and or wandering behaviors receive adequate supervision to prevent accidents. The Immediate Jeopardy, that began on 3/23/24, was removed on 3/28/24 when the facility inserviced the staff 1-on-1 supervision and ensured the unsecured door was under supervision until it could be replaced, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This citation relates to Complaint IN00431134. 3.1-45(a)(2)			